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No. 09-____

In the Supreme Court of the United States

RAKESH WAHI, M.D.,

Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. The Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152, provides a hospital immunity from monetary damages for disciplining a doctor "*after*" providing "adequate notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). By contrast, the Act allows disciplining "immediately"—that is, *before* notice and a hearing or other "fair" procedures—only where "failure to take such an action may result in an imminent danger to the health of any individual." § 11112(c).

   Did the court below err in holding, in conflict with four other circuits, that a hospital can obtain immunity for disciplining a doctor immediately—before notice and a hearing—where the hospital concedes that it did not find or rely upon the possibility of imminent danger?

2. Under the Act, may an immunity determination be made by a jury, as the First and Tenth Circuits hold, or is a jury forbidden from making such a determination, as the Eleventh Circuit and Colorado Supreme Court hold—and as the Fourth Circuit effectively held here?

PARTIES TO THE PROCEEDINGS

Petitioner Rakesh Wahi was the plaintiff-appellant in the court below. Respondents Charleston Area Medical Center, Inc., Glenn Crotty, Jamal Kahn, H. Rashid, K.C. Lee, Andrew Vaughn, and John L. Chapman were defendant-appellees below. There are no other parties.

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INTRODUCTION

By twice misinterpreting the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152 ("HCQIA"), the decision below has created a new circuit split *and* widened a mature, acknowledged split on the federal standards for physician peer-review immunity. These twin errors are of signal importance to the health care industry and patients nationwide because they allow hospitals to summarily strip doctors of their credentials without any justification, depriving them of their livelihoods—and then take away their right to a jury.

The court of appeals' first error concerns immunity for a summary suspension of hospital privileges. Under the HCQIA, a hospital is immune from monetary damages for disciplining a doctor "*after*" providing "notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). By contrast, a hospital can discipline "immediately"—that is, *before* "notice and a hearing" or other "fair" procedures—only in "emergencies," when "failure to take such an action may result in an *imminent danger* to the health of any individual." § 11112(c)(2) (emphasis added). But even then, immunity is "subject to subsequent notice and hearing or other adequate procedures." *Ibid.*

Here, while conceding that petitioner was suspended immediately—that is, before receiving "notice and a hearing" or other "fair" procedures—the Fourth Circuit held that the hospital could ignore the "imminent danger" requirement and still obtain immunity if it *later* "me[t] the usual standard" of providing notice and a hearing or other fair procedures. In other words, under the decision below, a

doctor can be immediately suspended—without any "imminent danger"—so long as the hospital provides some procedures at some point.

This judicial rewriting of Congress' carefully calibrated regime is indefensible, as shown by four contrary circuit decisions squarely holding that, to preserve immunity for a summary suspension, imminent danger is required. Because the Fourth Circuit's reasoning is so obviously flawed, and because respondent *concedes* that it suspended petitioner "without a prior finding that he posed an imminent danger," Pet. 81a, the Fourth Circuit's resolution of this issue would be suitable for summary reversal.

With its second error, the decision below widens an acknowledged split over the availability of jury trials to determine federal immunity. The First Circuit holds that the statute "contemplates a role for the jury, in an appropriate case, in deciding whether a defendant is entitled to HCQIA immunity." *Singh* v. *Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25 (1st Cir. 2002). Indeed, "[t]he weight of authority" holds that the proper inquiry is "whether *a reasonable jury* could find that the defendants did not conduct the relevant peer review actions in accordance with one of the HCQIA standards." *Id.* at 33 (citing cases; emphasis added). The Tenth Circuit has reached the same conclusion. *See Brown* v. *Presbyterian Healthcare Servs*, 101 F.3d 1324 (10th Cir. 1994).

While the court below framed the issue in terms of what a "reasonable jury" could have concluded (see Pet. 14a), its application of this standard makes it clear that the Fourth Circuit will never send an HCQIA immunity issue to a jury. That court thus

aligned itself with the Eleventh Circuit, which, in acknowledged "*contradiction of the other circuits*," *Singh*, 308 F.3d at 34 n.7 (emphasis added), holds that "*[u]nder no circumstances* should the ultimate question of whether the defendant is immune from monetary liability under HCQIA be submitted to the jury," *Bryan* v. *James E. Holmes Regional Med. Ctr.*, 33 F.3d 1318, 1333 (11th Cir. 1994) (Tjoflat, C.J.). The Supreme Court of Colorado holds the same, *North Colorado Medical Center* v. *Nicholas*, 27 P.3d 828 (Colo. 2001), setting up an intra-state conflict with the Tenth Circuit.

The need for this Court's review is heightened by important practical and policy considerations. Granting hospitals blanket immunity for issuing what amount to summary professional death sentences will seriously compromise our nation's health care system—ruining careers, wasting expertise, and depriving patients of innovative and compassionate medical care. Indeed, as the due process requirements of the HCQIA reveal, the statute is designed to protect patients *and* doctors—not (as here) hospitals that punish excellent doctors for entertaining employment opportunities with competing hospitals.

This Court has not yet construed the landmark, two-decades-old HCQIA. It is thus all the more important—and timely—that the Court make clear that the HCQIA means what it says about what is required to issue an immediate suspension, and that doctors who build powerful records like the one here are entitled to take their cases to a jury.

OPINIONS BELOW

The opinion of the district court is reprinted in the appendix to this petition at 43a-74a, and is reported at 453 F. Supp. 2d 942 (S.D.W. Va. 2006). The Fourth Circuit's opinion affirming the decision of the district court (1a-40a) is reported at 562 F.3d 599 (4th Cir. 2009). The Fourth Circuit's order denying rehearing *en banc* (41a-42a) is unreported.

JURISDICTION

The opinion of the Fourth Circuit was entered on April 10, 2009, and the order of the Fourth Circuit denying petitioner's petition for rehearing *en banc* was entered on May 8, 2009. On July 28, 2009, Chief Justice Roberts extended the time for filing this petition to and including September 15, 2009. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This petition involves the HCQIA's "[s]tandards for professional review actions," 42 U.S.C. § 11112, which are reprinted in total in the appendix at 76a-79a, and which govern the federal immunity provided under section 11111 of the Act. Subsection (a) of those standards provides:

> **(a) In general**
>
> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken—
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

42 U.S.C. § 11112(a).

Subsection (c) provides:

(c) Adequate procedures in investigations or health emergencies

For purposes of section 11111(a) of this title, nothing in this section shall be construed as—

(1) requiring the procedures referred to in subsection (a)(3) of this section—

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

42 U.S.C. § 11112(c).

STATEMENT

In 1986, Congress passed the HCQIA to improve the quality of medical care by subjecting doctors' competence and professionalism to "effective professional peer review" that meets certain standards of due process. 42 U.S.C. §§ 11101(1), (3), 11112. In so doing, "[t]he statute attempts to balance the chilling effect of litigation on [physician] peer review with concerns for protecting physicians improperly subjected to disciplinary action." *Bryan*, 33 F.3d at 1333. In this case, the court below has dramatically altered that balance—in defiance of the HCQIA's plain language, in conflict with four other circuits, and at great cost to petitioner and our nation's health care system.

A. Statutory Framework

To strike the desired balance between effective peer review and protecting doctors from unjustified discipline, the HCQIA provides immunity from monetary damages for what the statute calls "professional review action[s]," 42 U.S.C. § 11111(a)(1), so long as those actions comply with certain statutory "safe harbor" procedures, § 11112(b). One safe harbor governs actions taken in the normal course of business, *ibid.*; a separate provision governs actions

taken "in investigations or health emergencies," 42 U.S.C. § 11112(c).

1. "Professional review actions." Under the HCQIA, "professional review action" is defined as:

> an action or recommendation of a professional review body * * * based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

§ 11151(9). Under this definition, a separate professional review action occurs *whenever* privileges are restricted. Thus, a suspension of privileges is a separate professional review action from outright revocation or a refusal to renew privileges. See *Poliner* v. *Texas Health Sys.*, 537 F.3d 368, 377 (5th Cir. 2008). Further, certain professional review actions must be reported to a national database, the National Practitioner Data Bank or NPDB, which a hospital must consult before hiring a physician. 42 U.S.C. §§ 11133-11135.

2. Due process requirements. For professional review actions not taken in "investigations or health emergencies" (42 U.S.C. § 11112(c)), the HCQIA provides a detailed list of procedures that, if followed, will enable a health care entity to be "deemed" protected under the statute. These include "adequate notice and hearing procedures"—which involve providing notice of the proposed action, the reasons for the action, and notice that the physician

has a right to request a hearing. §§ 11112(a)(3), 11112(b)(1). If the physician requests a hearing, the hospital "must" provide "notice stating—(A) the place, time, and date, of the hearing * * * and (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body." § 11112(b)(2)(A), (B).

While meeting these requirements automatically qualifies a health care entity for HCQIA protection, "failure to meet the [notice and hearing list of] conditions shall not, in itself, constitute failure to meet the [adequate notice and hearing procedures] standard." § 11112(b). Rather, the standard may be met by "[o]ther procedures that are fair to the physician under the circumstances." § 11112(a)(3). Further, a "professional review action shall be presumed to have met the [adequate notice and hearing standards] * * * unless the presumption is rebutted by a preponderance of the evidence." § 11112(a)(4).

3. **"[I]mmediate suspension."** All notice and hearing procedures can be temporarily foregone, however, in the case of "health emergencies." § 11112(c)(2). Thus, "an immediate suspension or restriction of clinical privileges" is not "preclude[ed]" "where the failure to take such an action may result in an imminent danger to the health of an individual" *and* "notice and hearing or other adequate procedures" are later provided. *Ibid.*

B. Background of This Dispute

A highly skilled heart surgeon whose professional training includes service at the legendary Mayo Clinic, Dr. Rakesh Wahi was recruited in 1992 from a successful surgical practice in Chicago by the Charleston Area Medical Center ("CAMC") in Charleston, West Virginia. JA 98. Measured by CAMC's own criteria and national standards, Dr. Wahi achieved the best patient outcomes at CAMC. PFN 37-38, 40.[1] The mortality rate for Dr Wahi's patients was three times *lower* than the national average; and CAMC entrusted Dr. Wahi with the care of its high-risk patients. PFN 37-38, 40. In July 1994, Dr. Wahi launched his own surgical practice and began exploring the possibility of associating with surgeons at a neighboring hospital, Raleigh General. .JA 967.

1. CAMC's investigations and Dr. Wahi's exoneration. During the next few years, CAMC repeatedly investigated and temporarily suspended Dr. Wahi. Pet. 3a-4a. While these investigations were being conducted, however, the duly constituted peer review committee of CAMC charged with continuously monitoring CAMC's physicians evaluated Dr. Wahi's treatment of his patients and found it to be within the required standard of care. JA 967, 1015. And in April 1999, CAMC's Credentials Committee recommended Dr. Wahi's reappointment to the medical staff at CAMC for another year. JA 532, 963.

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[1] "PFN" stands for "Plaintiff's Fact Number," and refers to the paragraph number in the Statement of Controverted Material Facts and Counterstatement of Material Facts in the district court.

But shortly thereafter, when Dr. Wahi began treating a patient who had been referred to Dr. Wahi by Bluefield Regional Hospital—approximately 100 miles away—the Credentials Committee abruptly rescinded its favorable recommendation without notifying Dr. Wahi. JA 572-73, 975. The Committee then formally asked CAMC's Chief of Staff to conduct an "investigation and an appropriate suspension of Dr. Wahi's clinical privileges for treating the Bluefield patient." JA 572.

Before the investigation began, however, the Committee tentatively concluded that treatment of the patient was outside the scope of Dr. Wahi's delineated clinical privileges. *Ibid.* Specifically, Dr. Wahi was accused of caring for a patient (who was in his fifties) that CAMC deemed too high-risk. There was no dispute that Dr. Wahi's surgery benefited the patient. JA 721, 730-732, 744.

Led by senior CAMC officials, the investigation report exonerated Dr. Wahi. With the help of an external reviewer, the Chief of Staff conducted the investigation along with the Chief of the Department. Together, they concluded that Dr. Wahi's treatment "did *not* fall outside of his delineated clinical privileges." JA 964. (emphasis added).

2. CAMC's summary suspension of Dr. Wahi. Despite this exculpatory report, CAMC took an adverse "peer review action" against Dr. Wahi, directing its Chief of Staff to immediately suspend Dr. Wahi's privileges. JA 189, 600-602, 965. Two days later, CAMC notified Dr. Wahi of the suspension. Notably, the letter was bereft of any suggestion that

Dr. Wahi posed an imminent danger to his patients or any "danger" at all. JA 586.

Indeed, CAMC's Chief of Staff was later asked: "If you had seen a danger to the patient would you have taken steps to stop it then?" He responded, "Absolutely." JA 609. Further, the Chief of Staff testified that "Dr. Wahi [was allowed] to manage the medical treatment of the two patients currently in-house" *after* his summary suspension. JA 605-06. And with respect to that continuing treatment, the Chief of Staff was asked and answered as follows:

> Q: Would you have allowed him to continue with that treatment after the suspension if you thought he posed an imminent danger to those two patients?
>
> A. No.

JA 605-06.

Further, the Chief of Staff's Note to file, dated two days after the summary suspension, and describing its rationale, makes no reference to imminent danger. Rather, it concerns Dr. Wahi's "inability to follow procedural guidelines outlined by the Committee" and "diminishing trust between us and him, as well as the Credentials Committee and him." JA 965. Witnesses, staff members, and physicians consistently disclaimed any finding of or reliance upon any imminent danger. JA 322, 600, 800, 830, 887, 1006-1008, 1012.

A second letter in August 2009 stated that Dr. Wahi was entitled to a hearing if a written request

was received within four weeks.[2] Less than two weeks later, Dr. Wahi submitted a written request for a hearing. JA 648. Dr. Wahi also requested: (i) a more particularized statement of the charges; (ii) the factual predicate for the charges; (iii) access to related documents in CAMC's possession; and (iv) a list of witnesses that CAMC intended to call. JA 649-650.

Almost three months later, CAMC notified Dr. Wahi that a panel had been appointed to hear his appeal. JA 672-78. The letter said that senior CAMC *lawyers* would both serve as the presiding officer and represent CAMC. *Ibid.* The letter did not, however, provide a date or time for the hearing; nor did it identify CAMC's proposed witnesses. Another letter was sent to the Board members, requesting that they work with the President to schedule a hearing. JA 654. CAMC's lawyer sent two letters to Dr. Wahi that, among other things, asked him to let CAMC know about any dates that were particularly bad. But CAMC never provided Dr. Wahi a witness list—which would have enabled him to determine how long he would need to prepare, whom he should call as *his* witnesses, and when they were available for a hearing. Nor did CAMC itself schedule the hearing even though, in its final letter, it assured Dr. Wahi that it *would* set the hearing. JA 699. CAMC, moreover, never provided Dr. Wahi with the required witness list. Pet. 26a, 30a.

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[2] This letter also notified Dr. Wahi that the Credentials Committee had recommended that he be denied reappointment to the medical staff. JA 647. But that request has never been acted upon by CAMC's board.

Faced with CAMC's declared plan to set a hearing conducted by its own lawyers, and without providing a list of witnesses, in 2000 Dr. Wahi filed suit in West Virginia state court, requesting that a fair hearing panel review his suspension and denial of reappointment. JA 99-114. CAMC opposed Dr. Wahi's request, arguing that the state court need not intervene because CAMC was going forward with the hearing and would replace the panel members, including the presiding officer. JA 181, 183-187. Based on these representations, the court dismissed Dr. Wahi's suit without prejudice. JA 131-146.

3. Further exoneration by the West Virginia Board of Medicine. Rather than provide Dr. Wahi the hearing it promised, CAMC requested that the West Virginia Board of Medicine prosecute him. JA 147-150, 701. In November 2003, however, the Board dismissed CAMC's charges with prejudice, JA 254-265, as it had done with CAMC's two previous complaints against Dr. Wahi. The Board ordered all charges to be expunged from Dr. Wahi's record. JA 248-253.

C. This Litigation

That same year, Dr. Wahi filed suit alleging that CAMC's actions were taken, among other things, pursuant to a conspiracy by CAMC to monopolize thoracic and cardiovascular medicine and surgery "in the Charleston, Beckley, Bluefield, and Parkersburg area of West Virginia." Pet. 47a. CAMC defended on the ground that its actions were immune under the HCQIA. 48a.

1. The district court's grant of summary judgment without addressing the "imminent danger" requirement. The district court awarded summary judgment of HCQIA immunity to CAMC. It did so without considering Dr. Wahi's argument that his summary suspension was invalid because it was not justified by the requisite "imminent danger"—even though that issue had been raised and briefed extensively. Opp. to MSJ at 41-47.

Instead, the district court simply declared that Dr. Wahi received "procedures as are fair * * * under the circumstances" because he received, but had not responded, to two letters asking him to provide dates for a hearing. Pet. 57a, 60a. The district court did not explain how sending Dr. Wahi letters *after* his summary suspension remedied CAMC's failure to rely on any "imminent danger" in suspending him; how the letters constituted "procedures"; how such "procedures" were fair given CAMC's refusal to provide Dr. Wahi a witness list; why it was up to Dr. Wahi to set the hearing date when the HCQIA assigns that task to the hospital, 42 U.S.C. § 11112(b)(2)(A); or how to reconcile its conclusion with HCQIA's statement that "the right to the hearing may be forfeited," not if the doctor fails to provide hearing dates, but "if the physician fails without good cause to appear." 42 U.S.C. § 11112(b)(3)(B).

2. The Fourth Circuit's affirmance. The Fourth Circuit affirmed for essentially the reasons given by the district court—with one critical exception. Pet. 16a-31a. In contrast to the district court, the Fourth Circuit acknowledged Dr. Wahi's argument that the summary suspension was not supported by any "imminent danger." But it held that

the HCQIA's "emergencies" provision—subsection (c)—was not violated because it is *optional*.

Though CAMC had never suggested the idea, and without citing any precedent, the Fourth Circuit held that, as compared with the statute's main immunity provision—subsection (a)—the "health emergencies" provision in subsection (c) "sets out distinct ways in which a health care entity can be immune under the HCQIA *without* having complied with the usual requirements for claiming immunity." Pet. 17a; *accord id.* (health emergencies provision "presents additional routes to HCQIA immunity beyond that set forth in [adequate notice and hearing provisions]").

Consequently, the court reasoned, "[a]lthough Wahi may be correct that the facts show CAMC cannot assert immunity based on [the "health emergencies" provision of subsection (c)(2)], the only significance is that CAMC must meet the *usual* standard of qualifying for immunity set forth in [the adequate notice and hearing provisions of subsection (a)(3)]." Pet. 17a-18a. Thus, the panel concluded that the [redacted] Pet 18a n.18.

Having thus set aside the "imminent danger" requirement, the Fourth Circuit struggled to explain how Dr. Wahi received "procedures" that were "fair"—and indeed, extensively criticized CAMC. For example, the court stated that "CAMC's path to immunity in this case is not a recommended model."

Pet. 30a. In addition, "CAMC should have followed its Bylaws and the Procedures manual and provided Wahi a witness list." *Ibid.* Further, CAMC should have "simply set a prompt hearing." *Ibid.* According to the court, these were all "failures by CAMC." *Ibid.*

Whether CAMC would be immune despite these many "failures," the court acknowledged, would turn on "whether a reasonable jury, viewing all facts in a light most favorable to [Wahi], could conclude that he had shown, by a preponderance of the evidence, that [CAMC's] actions fell outside the scope" of the HCQIA's adequate notice and hearing provisions. Pet. 14a. But because Dr. Wahi did not provide "dates for a hearing" when asked—and solely for that reason—the Court concluded that Dr. Wahi had not "rebut[ted] the presumption that CAMC's actions satisfied" the HCQIA. *Id.* at 21a, 30a. And on that basis, the Fourth Circuit affirmed.

REASONS FOR GRANTING THE PETITION

Review is needed to resolve two circuit splits—one created by the decision below, the other widened by it. Moreover, by immunizing summary suspensions without the statutorily required possibility of imminent danger, and then denying the doctor an possibility of a jury trial, the Fourth Circuit has handed hospitals an all-purpose shield that will immunize them in virtually every case. Individually, each of the Fourth Circuit's errors flouts the HCQIA; but together they effectively make the HCQIA useless to protect doctors from sham peer review. Left uncorrected, the cost of this judicial failure will be counted, not only in ruined careers, but in artificially high prices caused by lack of competition, dimin-

ished innovation, and lack of adequate care for high-risk patients—particularly those residing within the Fourth Circuit.

I. With its misreading of the HCQIA, the decision below creates a conflict with decisions of the Third, Fifth, Eighth, and Ninth Circuits.

Reflecting the congressionally ordained balance between quality care and fairness, the HCQIA's general provisions—in subsection(a)—provide a hospital with immunity from damages when it disciplines a doctor "*after*" providing "adequate notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). Different standards apply, however, if the hospital disciplines the doctor "immediately"—that is, *before* notice and a hearing or other "fair" procedures. In that situation, the subject of subsection (c), immunity is "preclude[d]"—unless "failure to take such an action may result in an imminent danger to the health of any individual" *and* "subsequent notice and hearing or other adequate procedures" are provided. § 11112(c)(2) (emphasis added).[3] The Fourth Circuit re-wrote this sensible standard and, in so doing, placed itself in conflict with several other circuits.

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[3] Subsection (c)(1) also allows a hospital to suspend a doctor pending an "investigation." *Id.* § 11112(c)(1). But CAMC has never invoked this provision, no doubt because the record shows that the hospital's "investigation"—such as it was—had *already* been completed when Dr. Wahi was suspended.

A. The decision below flouts the plain language of the HCQIA.

In the court below, Dr. Wahi argued that CAMC "cannot claim immunity" because it summarily suspended him "without first finding that he posed an imminent danger to his patients." Pet. 16a. But the Fourth Circuit held that, even where summary suspension is at issue, the possibility of imminent danger is *optional*:

> [S]ubsection (c) presents additional routes to HCQIA immunity beyond that set forth in subsection (a)(3). Although Wahi may be correct that the facts show that CAMC cannot assert immunity based on (c)(1) or (c)(2), the only significance is that CAMC must meet the usual standard of qualifying for immunity set forth in subsection (a)(3).

Pet. 17a. Consistent with that logic, the Fourth Circuit reasoned that, as to the "imminent danger" provision, [redacted] Pet 18a n. 18.

1. The Fourth Circuit's approach violates the plain text of the "emergencies" provision. By its terms, that provision "*preclude*[s]" immunity for an "immediate suspension" unless two conditions are met: first, it must be the case that "failure to take such action may result in an imminent danger to the health of an[] individual"; and second, the doctor must be provided "subsequent notice and hearing or other adequate procedures." 42 U.S.C. § 11112(c)(2) (emphasis added).

It cannot be true, then, that a hospital can take an alternative "route" to immunity for a summary suspension merely by "meet[ing] the usual standards of qualifying for immunity set forth in subsection (a)(3)." Pet. App. 17a-18a. To meet the standard of subsection (a)(3), the required notice, hearing, and/or "other procedures" must occur "*before*" the "*proposed*" peer review action—here, a suspension. § 11112(a)(3), (b)(1) (emphasis added). By definition, however, in the case of an immediate suspension such procedures occur *after* the suspension—by which point the "proposed" action is not merely "proposed," but has already occurred. Such post-discipline procedures therefore cannot satisfy the requirement that the procedures come "before" the discipline.

Furthermore, the Fourth Circuit's reading would eliminate from the "emergencies" provision the phrase "imminent danger." The substantive requirements of subsection (a)(3)—"adequate notice and hearing" or "other fair procedures"—are repeated in the "emergencies" provision, which expressly requires such procedures "subsequent" to an immediate suspension. § 11112(c)(2). Thus, Congress considered whether providing later procedures constituted an "additional route[]" to immunity (Pet. 17a), and decided that it did—but only "*where the failure to [suspend] may result in an imminent danger.*" § 11112(c)(2) (emphasis added). The decision below reads this phrase out of existence, rendering the "additional" route no different than the original. This is re-drafting in the guise of interpretation.

2. The Fourth Circuit's interpretation also contravenes the "emergencies" provision's express pur-

pose. By creating a provision for "emergencies," Congress ensured that, when a hospital issues what amounts to a nationally published professional death sentence, there is an exigent reason for it—namely, that patient health "may" be in "imminent danger." § 11112(c)(2).

It is thus preposterous to suppose, as the Fourth Circuit's holding requires, that Congress intended hospitals (1) to be able to defrock doctors without warning when there is no "emergenc[y]," and (2) to cure that assault on a doctor's rights by providing him "notice and a hearing" later on. Notice of what? By then the doctor has already lost his job and livelihood—information he will have *already* learned when his summary suspension letter arrives in the mail or he arrives at the hospital only to be turned away.

This deeply flawed interpretation should not be allowed to stand. Indeed, if the Court so chose, it would be a good candidate for summary reversal.

B. The decision creates a conflict with decisions in four other circuits.

Whereas no court has taken the course of the Fourth Circuit here, four circuits squarely hold that, when a hospital such as CAMC imposes a summary suspension, a showing of "imminent danger" is required. The decision below thus creates a circuit split that subjects doctors in the Fourth Circuit to a substantial risk not faced by doctors practicing in the rest of the Nation.

1. The Ninth Circuit's decision in *Fobbs* v. *Holy Cross Health Sys. Corp.*, 29 F.3d 1439 (9th Cir. 1994), *partially overruled on other grounds in Davi-*

ton v. *Columbia/HCA Healthcare Corp.*, 241 F.3d 1131 (9th Cir. 2002), is particularly instructive. There, a doctor argued that "defendants' manner of giving him notice" of his discipline was unfair "barring an emergency 'threatening imminent danger.'" *Fobbs* v. *Holy Cross Health Sys. Corp.*, 789 F. Supp. 1054, 1068 (E.D. Cal. 1992). But the district court ducked the question whether "imminent danger" justified the notice afforded, changing the subject by pointing out that "[t]here is no dispute that plaintiff was given notice" of *later* "hearings." *Ibid.*

The Ninth Circuit rejected the district court's attempt to rely on this later notice; instead, it published a decision holding that a finding of imminent danger *is* required. Then, in response to the doctor's argument that "the statute requires that there *be* 'imminent danger to the health of any individual' before there may be a summary restriction," the Ninth Circuit held that the statute "*requires* that the danger *may* result." 29 F.3d at 1443 (first emphasis added).

Here, by contrast, instead of ducking the question of imminent danger, the Fourth Circuit erroneously and inexplicably construed it as optional. But *Fobbs* forbids that as well. Because *Fobbs* holds that the HCQIA "requires" (*ibid.*) that danger may result, and because the decision plainly teaches that notice of a later hearing is not enough (else the opinion would not have been published), the Fourth Circuit's holding that later notice and procedures *are* enough is in plain conflict with *Fobbs*.

2. The decision below also conflicts with decisions of the Fifth, Eighth, and Third Circuits.

In *Poliner*, for example, a doctor's privileges were temporarily suspended "to allow for an investigation to determine whether other action, such as a suspension, was necessary." 537 F.3d at 382. After the investigation committee "concluded that [the doctor] gave substandard care in half of the cases reviewed, and considering the seriousness of the diagnostic error" in a "cardiac catheterization," the Fifth Circuit reasoned that "Defendants were fully warranted in concluding that failing to impose further temporary restrictions 'may result' in imminent danger." *Ibid.*

Nor was this conclusion optional: The Fifth Circuit held that a finding that "failure to act 'may result in an imminent danger to the health of any individual" was "*require[d].*" *Ibid.* (quoting 42 U.S.C. § 11112(c)(2)) (emphasis added).

The court then explained how "the process provisions of the HCQIA work in tandem":

> legitimate concerns [i.e., the possibility of imminent danger] lead to temporary restrictions and an investigation; *an investigation reveals that a doctor may in fact be a danger*; and in response, the hospital continues to limit the physician's privileges. The hearing process is allowed to play out unencumbered by the fears and urgency that would necessarily obtain if the physician were midstream returned to full privileges during the few days necessary for a fully informed and considered decision * * * *.

537 F.3d at 384 (emphasis added). When the doctor in *Poliner* countered that summary suspension was only allowed in "extraordinary cases in which a physician suddenly becomes impaired or grossly incom-

petent," the Fifth Circuit ruled that "the plain language of the statute is not so limited"—but in so doing cited multiple cases from other courts *requiring* at least the possibility of "imminent danger." *Id.* at 382-383 & n.48.

At every turn, CAMC departed from this statutory roadmap—including skipping the required judgment about imminent danger. To begin with, the Chief of Staff conducted his investigation, which paralleled an outside investigation, *without* suspending Dr. Wahi. This suggests that there was no imminent danger to anyone—a conclusion confirmed when the Chief of Staff reported that Dr. Wahi's treatments "did *not* fall outside of his delineated clinical privileges." JA 964 (emphasis added).

Then, however, as CAMC admitted, "CAMC * * * suspend[ed] [Dr. Wahi] *without* a prior finding that he posed an imminent danger." Pet. 81a (emphasis added). And on that same day, Dr. Wahi was allowed to treat two patients. JA 605-606. It was only afterward that the parties began negotiating over the hearing that became the focus of the Fourth Circuit's decision. See Pet. 27a-31a.

By that time, though, the statutory scheme described in *Poliner* had already been shredded. Albeit under protest, Dr. Wahi was negotiating for a hearing under a statutorily invalid summary suspension. Under the plain language of the HCQIA and the holding of *Poliner*, CAMC had already forfeited its immunity—by suspending Dr. Wahi *without* concluding that there was any possibility of imminent danger.

Like the doctor in *Poliner*, the doctor in *Sugarbaker* v. *SSM Health Care*, 190 F.3d 905 (8th Cir. 1999), also argued that the defendant hospital's "precautionary suspension was improper." *Id.* at 917. The Eighth Circuit upheld the suspension, however, only because "review of 24 of Dr. Sugarbaker's surgical cases raised concerns" about patient safety, and because "under the HCQIA's emergency provisions, summary suspensions * * * do not result in the loss of immunity 'where the failure to take such an action may result in an imminent danger to the health of any individual.'" *Ibid.* (quoting 42 U.S.C. § 11112(c)(2)). When the doctor objected that he had no patients at the time of the suspension and thus any supposed danger could not have been imminent, the court observed that the statute merely "*requires*" the possibility of imminent danger—a condition amply met there. *Ibid.* (quoting *Fobbs*, 29 F.3d at 1443 (emphasis added)). Chief Judge Becker reached the same conclusion for the Third Circuit in *Brader* v. *Allegheny General Hospital*, 167 F.3d 832 (3d Cir. 1999).[4]

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[4] There, a doctor challenged a hospital's decision to "summarily suspend" his privileges to repair abdominal aortic aneurisms ["AAA"] after, among other things, the director of the Division of General Surgery observed a patient die on the operating table "from bleeding from the injuries" sustained *during surgery*. 167 F.3d at 835. The doctor complained that the hospital "did not give [him] advance warning" before his AAA privileges were "summarily suspended." *Id.* at 842. The Third Circuit, however, held that the suspension was "covered by § 11112(c), which provides that the [adequate notice and hearing provisions] do not preclude an immediate suspension * * * where the failure to take such an action may result in an imminent danger to the health of any individual." *Ibid.*

In these circuits, the cases foreclose the Fourth Circuit's holding that a finding of imminent danger is optional. All four circuits have already held it is required. *Fobbs*, 29 F.3d at 1443 ("requires"); *Poliner*, 537 F.3d at 382 ("requires"); *Sugarbaker*, 190 F.3d at ("requires"); *Brader*, 167 F.3d at 842 (immunized suspension not "preclude[d]" with finding of imminent danger).

C. The decision below is an especially attractive candidate for review because CAMC concedes it did not rely on any imminent danger.

This case is a particularly good candidate for review and resolution of this issue because there is no question whether CAMC made a finding of imminent danger or relied upon any such finding in suspending Dr. Wahi. CAMC has expressly conceded it did not.

In the court below, Dr. Wahi focused extensively in his opening brief on the lack of a finding of imminent danger, noting that this destroyed CAMC's immunity under the plain language of the statute. Appellant's Br. at 20-24. In response, CAMC readily agreed that it did not rely on any imminent danger: It acknowledged that Dr. Wahi had been "suspend[ed] * * * without a prior finding of imminent danger," Pet. 81a, but argued that it did not thereby "violate * * * HCQIA." *Id.* According to CAMC, it nevertheless remained immune because the summary suspension was allowed under its *procedures manual*.

Because in the Ninth, Fifth, Eighth, and Third Circuits imminent danger is "required," CAMC's

concession that it suspended Dr. Wahi "without a finding of imminent danger" would have voided CAMC's immunity as a matter of law. The lack of a material factual question on this dispositive point makes this case an especially good candidate for review—and, indeed, summary reversal on this issue.

II. The Fourth Circuit widened a recognized circuit split over whether a hospital's federal immunity can be decided by a jury.

In addition to creating a circuit split over the proper construction of the HCQIA's "immediate suspension" provisions, this case deepens a pre-existing and acknowledged split involving an HCQIA plaintiff's access to a jury. This Court has long instructed that "[m]aintenance of the jury as a fact-finding body is of such importance that any seeming curtailment of the right to a jury trial should be scrutinized with the utmost care." *Chauffeurs, Teamsters, & Helpers, Local 391* v. *Terry*, 494 U.S. 558, 565 (1990) (citation omitted). Yet the decision below denies that right in all cases, in conflict with decisions of the First and Tenth Circuits, but in accord with decisions of the Eleventh Circuit and Supreme Court of Colorado.

A. The decision below effectively denies all HCQIA plaintiffs a jury trial, aligning the Fourth Circuit with the Eleventh and against the First and Tenth Circuits.

As we have shown, the summary suspension was invalid as a matter of law because CAMC concededly made no prior finding that Dr. Wahi may have posed an imminent danger. See discussion. *supra*, at 17-25. The court below avoided this conclusion only by

misreading the HCQIA's "imminent danger" requirement. But in holding that CAMC avoided that requirement by *later* providing "fair" procedures, the Court brought itself into conflict with decisions of other circuits that, at a minimum, would have required a jury to decide that question.

1. According to the Fourth Circuit, whether the procedures were "fair * * * under the circumstances" (§ 11112(a)(3)) was an exceedingly close question. Rather than applauding CAMC's approach, the Fourth Circuit firmly admonished that CAMC "should have followed its Bylaws and Procedures Manual," not to mention the requirements of the HCQIA, "and provided Wahi a witness list." Pet. 30a. Likewise, CAMC should have "simply set a prompt hearing." And so, because of these "failures by CAMC," the Fourth Circuit declared that CAMC's "path to immunity in this case is not a recommended model." *Ibid.*

Rather than send this case to a jury, however, the Fourth Circuit purported to break the tie on the issue of whether Dr. Wahi received "fair" procedures by invoking the HCQIA's presumption that hospital procedures are fair. Pet. 30a-31a. But Dr. Wahi had already overcome that presumption by establishing that CAMC had never set a hearing or provided him its list of witnesses. Indeed, if Dr. Wahi's showing had been any stronger, he would have failed to receive a jury trial for a different reason: He would have been entitled to judgment as a matter of law. Under the Fourth Circuit's reasoning, then, the category of HCQIA plaintiffs who receive jury trials is an empty set.

By effectively creating this no-jury standard, the Fourth Circuit has aligned itself with the Eleventh Circuit and the Supreme Court of Colorado. In *Bryan*, the Eleventh Circuit held that "[u]nder no circumstances should the ultimate question of whether the defendant is immune from monetary liability under HCQIA be submitted to the jury," *Bryan*, 33 F.3d at 1333.[5] The Supreme Court of Colorado reached the same conclusion in *North Colorado Medical Center* v. *Nicholas*, 27 P.3d 828, 838 (Colo. 2001) ("[i]mmunity under the HCQIA is a question of law for the court to decide").

2. At the same time that it effectively sided with these courts, the Fourth Circuit set itself against the First and Tenth Circuits, which hold that under the HCQIA jury trials may be and often are required.

For example, according to the First Circuit's decision in *Singh*, "entry of summary judgment *does* * * * *violence* to the plaintiff's right to a jury trial" unless "there are no genuine disputes over material historical facts, and * * * the evidence of reasonableness * * * is so-one sided that no reasonable jury could find that the defendant health care entity failed to meet the HCQIA standards." 308 F.3d at 36 (emphasis added). In so holding, moreover, the First Circuit recognized its square conflict with the Eleventh Circuit's decision in *Bryan*:

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[5] Indeed, the Fourth Circuit's reasoning is more extreme than the Eleventh Circuit. At least the Eleventh Circuit allows a jury to consider certain immunity-related fact questions. *Bryan*, 33 F.3d at 1333; see also *Singh*, 308 F.3d at 34 n.7 (noting overlap between fact questions related to immunity and ultimate immunity determination).

> [g]iven *Bryan*'s internal inconsistency, and its contradiction of the other circuits' holding that a jury may in principle make a HCQIA determination we decline to adopt its designation of HCQIA determinations as pure questions of law off limits to a jury.

Id. at 35. Before the decision below, then, there was already an acknowledged circuit split over whether a jury could consider the immunity question in this case.

The decision below also pits the Fourth Circuit against the Tenth Circuit, which likewise requires jury trials when merited in HCQIA cases—and indeed, has granted such a trial. In *Brown* v. *Presbyterian Healthcare Services*, 101 F.3d 1324 (10th Cir. 1994), the court awarded a jury trial where the doctor presented only one expert witness, who was contradicted by the hospital's many experts. Despite the obvious imbalance, keeping such a difference of opinion from a jury, the court held, "would be in direct contravention to Congress' intention * * * and would abrogate the jury's responsibility to weigh the evidence and determine the credibility of witnesses." *Id. at* 1334 n.9.

Responding to an argument that in light of the strength of the hospital's case the doctor's single witness could not raise a material issue, the Tenth Circuit noted that the "entire jury system is anchored to the jurors' determination of credibility of witnesses and the weight to be given to their testimony." *Ibid.* (citation omitted). And on that basis the court *granted* a jury trial to the doctor—in

clear conflict with the Eleventh Circuit, the Colorado Supreme Court, and the decision below.

Moreover, in light of Colorado Supreme Court's later rejection of jury trials in HCQIA cases (see *North Colorado Medical Center*, *supra*), a litigant in Colorado can obtain a jury trial in federal court—under *Brown*—but *not* in state court.

In sum, by using the statutory presumption to resolve the fact issues that were clearly presented in the evidence below, the Fourth Circuit effectively created a no-jury-trial rule and thus widened an established conflict.

B. This case is an excellent vehicle with which to resolve the conflict.

This case provides an effective vehicle by which to resolve the acknowledged split on the availability of a jury trial in HCQIA cases, because there is no doubt that the Tenth and First Circuits, if they had reached the issue, would have awarded a jury trial as to either (1) whether there was the possibility of imminent danger, or (2) whether CAMC's procedures were "fair" under the circumstances, or both.

1. To be sure, we believe Dr. Wahi was and is entitled to summary judgment as to his summary suspension: By failing to make any finding or showing of the possibility of imminent danger, CAMC could not, as a matter of law, invoke the immunity provided in paragraph (c)(2). And by failing to provide any notice, hearing or other procedures *before* the suspension, CAMC could not, as a matter of law, obtain immunity under the more general provision of (a)(3). See discussion, *supra*, at 17-25. But if that were not so, Dr. Wahi would certainly be entitled to

a jury trial on CAMC's immunity for his summary suspension.

The only evidence that could possibly create a fact issue on "imminent danger" came from the deposition testimony of the CAMC official who summarily suspended Dr. Wahi but allowed him to treat patients that same day. The official admitted that he would not have allowed Dr. Wahi to treat patients if he had been an imminent danger. [redacted] Pet. 18a n.18. But CAMC has never relied upon that assertion as its basis for the summary suspension, and as noted, it conceded it never made a finding of imminent danger. Pet. 81a. But even if CAMC had relied upon the Chief of Staff's assertion, that assertion *at best* creates a genuine dispute over a material historical fact and creates a question about the Chief of Staff's credibility. Both lie squarely within the unique province of the jury. See *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986).

Indeed, keeping a jury from addressing this issue directly contravenes the holding of the Tenth Circuit in *Brown*, which awarded a jury trial on a far lesser showing to avoid "abrogat[ing] the jury's responsibility to weigh the evidence and determine the credibility of witnesses." *Brown*, 101 F.3d at 1334 n.9. So too under *Singh*, which declares that "entry of summary judgment *does* * * * *violence* to the plaintiff's right to a jury trial unless "there are no genuine disputes over material historical facts." 308 F.3d at 36 (emphasis added).

2. Even assuming the issue of "imminent danger" could be set aside, there are certainly material issues of fact as to whether CAMC's procedures were "fair to [Dr. Wahi] under the circumstances," 42 U.S.C. § 11112(a)(3). Here again, the Tenth and First Circuits undoubtedly would have come out the other way.

The circumstances here include multiple acknowledged "failures" by CAMC, including its refusal to provide Dr. Wahi a witness list, which is why the Fourth Circuit described its "path to immunity" as "not a recommended model." Pet. 30a. The salient circumstances also include Dr. Wahi's three exonerations—with prejudice—by the State Board of Medicine. JA 248-255.

Thus, Dr. Wahi's case is far stronger than that in *Brown*, which granted a jury trial to the doctor there. As noted, in *Brown*, the doctor had a single expert witness in his favor, and the Tenth Circuit held that a jury trial was required. 101 F.3d at 1334 & n.9. Here, by contrast, Dr. Wahi has far more than a single expert supporting his position on the key factual issues. But rather than sending this sharply disputed case to a jury, the Fourth Circuit improperly "weigh[ed] the evidence and determine[d] the truth of the matter" itself. *Anderson*, 477 U.S. at 249.

In so doing, the court allowed a *single* supposed fact—Dr. Wahi's lack of response to requests for dates for a hearing, *for which he had not been provided a witness list*—to be dispositive. Here again, the court ignored numerous countervailing issues, including the following:

- how Dr. Wahi could provide dates without knowing how many witnesses there would be, who they were, which witnesses *he* thus would need to call, and when they were available;
- that the last letter to Dr. Wahi promised that *CAMC* would set the hearing, JA 699; or
- that, according to the HCQIA, "the right to the hearing may be forfeited," but only "if the physician fails, without good cause, to *appear*." 42 U.S.C. § 11112(b)(3)(B) (emphasis added).

Whether CAMC provided procedures "fair" to Dr. Wahi under these circumstances was for a jury to decide. § 11112(a)(3); Pet. 19a. Indeed, if a physician cannot go before a jury of his peers under such circumstances, the jury trial right has become essentially worthless. Cf. *Clark* v. *Columbia/HCA Info. Serv's, Inc.*, 25 P.3d 215, 223 (Nev. 2001) (reversing summary judgment of HCQIA immunity because premised merely on "[o]ne instance of an objective basis for discipline").

In short, there is unlikely ever to be a better candidate to resolve the split between the two circuits—the First and Tenth—that require jury trials in cases like this, and the two circuits—the Eleventh and the Fourth—plus the Supreme Court of Colorado, that preclude them.

III. Left undisturbed, the decision will let hospitals run roughshod over physicians' rights, to the detriment not only of doctors, but of patients and the entire health-care system.

The decision below also merits review because it is exceptionally important to the nation's health care. As the amicus brief below by the Association of American Physicians & Surgeons ("AAPS") showed, there has long been a problem of anticompetitive manipulation of peer review to eliminate innovative or popular physicians and to retaliate against physicians deemed to provide "too much" care to high-risk or critically ill patients. AAPS Br. 14-18. The Fourth Circuit's decision will compound this problem, allowing hospitals to brand doctors with a professional "scarlet letter," which by statute they must wear in all fifty states, *before any problem is found with the doctor's competence.* Not only will this deprive patients of the services of extremely talented physicians like Dr. Wahi, it will also foil Congress' "attempt[] to balance the chilling effect of litigation on peer review with concerns for protecting physicians." *Bryan*, 33 F.3d at 1322.

1. The Fourth Circuit's holding that a hospital can suspend a doctor summarily without any justification gives hospitals enormous power. And that power is uniquely devastating, not only because it can be exercised capriciously, but because it enables hospitals to "kneecap" doctors at the very threshold of litigation—preventing them from effectively protesting both the suspension *and* any later professional review action. After all, when a doctor is summarily suspended, he loses his livelihood; and is

thus handicapped in hiring a talented lawyer who can mount a defense against a powerful and well-financed hospital or health system. This is contrary to the express purpose of the HCQIA, which, by allowing summary suspensions only on the basis of "imminent danger," forbids issuing professional death sentences where risk to patients is lacking.

By eliminating jury trials, the Fourth Circuit has done violence to HCQIA's overriding purpose. The statute is crafted not only to protect the peer review process from unmeritorious challenges, but also to guard doctors from being stripped of their professional licenses without receiving basic due process. By allowing summary suspensions without justification, the Fourth Circuit destroys this congressionally ordained balance. See *Bryan*, 33 F.3d at 1322.

2. As the AAPS brief explained, the cost of this misguided decision will include not only needlessly ruined careers and wasted expertise, but the loss of innovative and compassionate medical care. Sham peer review is already a nationwide problem, which the decision below promises to make worse. See AAPS Br. 16 (citing multiple medical journals documenting epidemic of sham peer review).

Unlike the record in this case, moreover, which is notably bereft of a single patient suffering under Dr. Wahi's care, every other leading circuit court decision involved serious wrongdoing. For example:

- "the committee concluded that 27" of Dr. Mathews' "cases evidenced a substandard level of care" and "[t]wenty-three of those cases * * * involved spine surgery," *Mathews* v. *Lancaster Gen. Hosp.*, 87 F.3d 624, 629 (3d Cir. 1996);

- "review of 24 of Dr. Sugarbaker's surgical cases raised concerns with respect to Dr. Sugarbaker's practice," *Sugarbaker*, 190 F.3d at 917;
- "of the 5 people who had done [a certain type of procedure] one surgeon accounted for 50 percent of the mortality," and "[t]hat one surgeon was Brader," *Brader*, 167 F.3d at 836.

Thus, while the Fourth Circuit characterized Dr. Wahi as "not a first-time offender" Pet. 29a, it ignored the fact that *none of CAMC's reports about Dr. Wahi was ever vindicated.* Indeed, CAMC's own investigation vindicated Dr. Wahi; and the medical board of West Virginia has investigated Dr. Wahi *three times* at CAMC's request—and has cleared him every single time. JA 248-265.

In short, if Dr. Wahi can be summarily suspended, any physician can be. "Peer review" that allows such a travesty is not worthy of the name, and it is expressly forbidden by the HCQIA. Unless this Court grants review, such misadventures will only be further multiplied—to the detriment of excellent physicians such as Dr. Wahi, and of patients nationwide. AAPS Br. 12-18.

3. Finally, the decision below can only encourage the departure of physicians from the five states within the Fourth Circuit—Maryland, Virginia, West Virginia, North Carolina, and South Carolina—and hamper efforts to recruit excellent physicians to practice in those states. Given the option, what physician would choose to practice where the local hospital—the lifeblood of her medical practice—can suspend her privileges on a whim and without any possibility of recourse to a jury?

Protecting hospitals and peer reviewers from frivolous suits is one thing, but protecting them from *any* legal challenge is quite another. "Absolute power corrupts absolutely." J. Acton, *Essays on Freedom and Power* 364 (H. Finer ed. 1948). And good doctors will be deterred from practicing in any area where the law confers such power on local hospitals.

CONCLUSION

This case gives the Court an opportunity to resolve both a new and a pre-existing circuit split on two issues of critical importance to doctors, hospitals, and our entire health-care system. It also provides an opportunity to rein in the overly deferential approach to peer-review immunity embodied in the decision below, and to prevent that approach from spreading to other circuits.

Petitioner thus respectfully urges the Court to grant plenary review of both questions presented. At a minimum, the Court should grant review of the first question and, if it believes plenary review is not warranted, summarily reverse the decision below.

Respectfully submitted,

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September 2009

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

Rakesh WAHI, *Plaintiff-Appellant,* v. CHARLESTON AREA MEDICAL CENTER, INCORPORATED, a West Virginia Corporation; Glenn Crotty; John Does I-X, *Defendants-Appellees,* and Jane Does I-X; Jamal Kahn; H. Rashid; K.C. Lee; Andrew Vaughn; John L. Chapman, *Defendants.*	No. 06-2162
Association of American Physicians and Surgeons, Incorporated, *Amicus Supporting Appellant.*	

Appeal from the United States District Court for the Southern District of West Virginia, at Charleston. Joseph R. Goodwin, Chief District Judge.

(2:04-cv-00019)

Argued: December 2, 2008

Decided: April 10, 2009

Before GREGORY and AGEE, Circuit Judges, and Rebecca Beach SMITH, United States District Judge for the Eastern District of Virginia, sitting by designation.

Affirmed by published opinion. Judge AGEE wrote the opinion, in which Judge GREGORY and Judge SMITH joined.

COUNSEL

ARGUED: Kenneth Winston Starr, PEPPERDINE UNIVERSITY SCHOOL OF LAW, Malibu, California, for Appellant. Richard D. Jones, FLAHERTY, SENSABAUGH & BONASSO, P.L.L.C., Charleston, West Virginia, for Appellees.

ON BRIEF: John C. Yoder, Harpers Ferry, West Virginia, for Appellant. David S. Givens, FLAHERTY, SENSABAUGH & BONASSO, P.L.L.C., Wheeling, West Virginia, for Appellees. Andrew L. Schlafly, Far Hills, New Jersey, for Amicus Supporting Appellant.

OPINION

AGEE, Circuit Judge:

Rakesh Wahi, M.D., appeals the district court's judgment dismissing his numerous state and federal claims brought against Charleston Area Medical Center, Inc. ("CAMC") regarding the suspension of his medical privileges. The district court concluded most of Wahi's claims were barred because CAMC qualified for immunity from suit under the Health Care Quality Improvement Act ("HCQIA" or "the Act"), 42 U.S.C.A. § 11101, *et seq.* (West 2005). For this reason, and because the district court found Wahi's other claims failed on the merits, the court

awarded CAMC and Dr. Glenn Crotty[1] summary judgment. For the reasons set forth below, we affirm the judgment of the district court.

I.

CAMC is a privately-run hospital operating in Charleston, West Virginia. Wahi, who is licensed to practice medicine in West Virginia, began working as a cardio-thoracic surgeon at CAMC in January 1993. (J.A. 98.) The following year, Wahi started his own practice, but retained clinical privileges at CAMC. Around the same time, he began discussions with a Beckley, West Virginia medical group about the possibility of associating with them. In November 1996, CAMC temporarily suspended Wahi's hospital privileges and, as required by statute, it notified the National Practitioner's Data Bank ("NPDB"),[2] of Wahi's suspension. CAMC later reinstated Wahi's clinical privileges on a provisional basis.[3] (J.A. 49;

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[1] Dr. Crotty served as Executive Vice President and Chief Medical Officer at CAMC during the relevant period of Wahi's employment; he is now the Chief Operating Officer at CAMC. (J.A. 70, 117.)

[2] The NPDB is a national clearinghouse designed to prevent incompetent doctors from simply moving to anew state that could not discover their prior poor performance. Under the HCQIA, hospitals are generally required to report to the NPDB adverse professional review action "affect[ing] the clinical privileges of a physician." *See* 42 U.S.C.A. § 11133(a)(1)(A) (West 2005).

[3] Wahi's status and privileges changed in subsequent periods, but at all relevant times, he only possessed provisional privileges at CAMC and he was subject to numerous restrictions, such as being required to get another doctor's approval before performing certain procedures and to have a proctor present during other procedures. Wahi was also barred from performing some procedures entirely. (J.A. 516-33, 655.)

294; 511-16.) Following Wahi's reinstatement, CAMC received reports of and investigated several allegations that Wahi violated the terms of his provisional clinical privileges, which again resulted in temporary suspensions of Wahi's privileges in 1998 and 1999. From 1996 to 1999, CAMC, as required by statute, reported Wahi to the NPDB a total of five times, although the exact nature of each of the reports before 1999 is not in the record. These prior suspensions and investigations are not at issue in this appeal.[4] (J.A. 50, 517-71.)

At the time of the events in question, Wahi was exercising provisional privileges at CAMC, and had requested reappointment for "an additional year ending February 26, 2000."[5] (J.A. 532-33, 572.) In May 1999, the CAMC Credentials Committee[6] ("Credentials Committee") recommended that Wahi's request be granted, but that his privileges remain

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[4] CAMC also filed several reports regarding Wahi's professional conduct with the West Virginia Board of Medicine.

[5] Under CAMC policy, an application for reappointment automatically extends the current appointment period until the request is acted on. (J.A. 477; Procedures Manual 2.1.1.1.) Wahi's application thus extended his previous year's appointment until final disposition of his application for reappointment.

[6] The Credentials Committee is composed of "one representative from each of [CAMC's] Medical Staff Departments" and two non-physician non-voting members of the Board. It is charged with investigating the "character, professional competence, qualifications and ethical standing of" CAMC physicians who have "completed applications for appointment or reappointment to the medical Staff," as well as requests for changes in privileges. The Credentials Committee then makes a recommendation to the Board on all such matters. (Bylaws 8.3.1, 8.3.2.1.) (J.A. 464.)

restricted "as currently in place with intensified review as outlined in the Medical Staff Procedures Manual."[7] (J.A. 532.)

By letter dated July 8, 1999, the Credentials Committee notified CAMC's Chief of Staff, **[REDACTED]**, that it was rescinding its earlier recommendation to renew Wahi's provisional clinical privileges.[8] This decision was made after receiving information that Wahi performed a **[REDACTED]**, which he was not permitted to do under the terms of his provisional clinical privileges. The Credentials Committee had also been apprised that Wahi failed to notify CAMC, as required by the by-laws, that he had voluntarily relinquished his clinical privileges at another hospital. The Credentials Committee requested "an investigation and appropriate suspension of Dr. Wahi's clinical privileges" in light of this new information of Wahi's continued failure to comply with the terms of his provisional clinical privileges. The Credentials Committee informed **[REDACTED]** that its recommendation had not been communicated to the CAMC Board of Trustees, and that Wahi would be given the opportunity to meet with them "prior to any final recommendation." (J.A. 572-73.)

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[7] Three documents set forth the rights and responsibilities between CAMC and its medical staff: the Medical Staff Procedures Manual ("Procedures Manual"), Medical Staff Bylaws ("Bylaws"), and Medical Staff Rules & Regulations.

[8] The district court incorrectly identified this letter as one addressed directly to Wahi. There is no indication in the record that Wahi received a copy of this letter or was made aware of the Credentials Committee's recommendation at that time.

By letter dated July 16, 1999, **[REDACTED]** informed Wahi that he had been requested to investigate the two claims raised in the Credentials Committee's letter. **[REDACTED]** asked Wahi to "respond to each of the [allegations] in writing as soon as possible." Attached to the letter were the relevant portions of the Bylaws pertaining to the alleged violations. (J.A. 115, 575-76.)

Between July 16 and July 30, in addition to meeting with **[REDACTED]** to discuss the July 16 letter requesting additional information from Wahi, Wahi wrote to **[REDACTED]**, **[REDACTED]**, and the Chairman of the Credentials Committee in order to provide an explanation of the events surrounding the allegations against him. The Credentials Committee scheduled a meeting with Wahi for August 3, 1999 to review his performance and consider his application, which was later rescheduled for August 17, 1999, at Wahi's request. (J.A. 742.)

On July 30, 1999, **[REDACTED]** summarily suspended Wahi's hospital privileges at CAMC. (J.A. 50.) By letter on the same date, CAMC formally notified Wahi that his "clinical privileges [were] hereby summarily suspended pursuant to Section 2.4.1, *Grounds for Summary Suspension* of the Procedures Manual, 'for the best interest of patient care.' " (J.A. 117.) His suspension was to "continue until resolution of [Wahi's] request for reappointment and any appeal/hearing, if requested, has been completed." (J.A. 117.) A copy of Article III of the Procedures Manual was attached to the letter, and Wahi was informed that he "may wish to avail [himself] of any rights available to [him] under Article III." (J.A. 117, 586.)

From the time of his suspension through the Credentials Committee meeting, Wahi engaged in ongoing correspondence and discussions with CAMC regarding preparation for that meeting and his application to renew clinical privileges. (See, e.g., J.A. 118-30, 654.) On August 17, 1999, the Credentials Committee met and Wahi testified, providing his response to the allegations against him. The Credentials Committee recommended denying Wahi's application for reappointment in a detailed August 26, 1999 letter. (J.A. 644-46.) By a separate letter, also dated August 26, 1999, CAMC informed Wahi of the denial of his request for reappointment of his clinical privileges and of his right to a hearing regarding this decision under Article III of the Procedures Manual. (J.A. 644-47.)

On September 8, 1999, Wahi, by counsel, requested a hearing regarding both his suspension and the decision not to renew his clinical privileges. On September 13, 1999, CAMC reported Wahi's summary suspension to the NPDB, (J.A. 962.), and to the West Virginia Board of Medicine. (J.A. 701.)

Correspondence during the next several months indicates on-going discussions between Wahi and CAMC regarding Wahi's access to his medical affairs/quality assurance file, his dislike of the composition of the hearing panel, and other aspects of the conduct of a hearing. CAMC repeatedly asked Wahi to provide "a series of convenient dates ... for the scheduling of" the requested hearing. (J.A. 762-63, 776.) Wahi has never provided CAMC with any dates on which he would be available for a hearing, and a hearing date was never set. (J.A. 760.)

In November 2000, Wahi filed a complaint in

West Virginia state court requesting that the court intervene in the CAMC peer review process, declare certain of CAMC's actions invalid, require CAMC to withdraw its reports to the NPDB and state Board of Medicine, and require a court-administered hearing that satisfied Wahi's various demands. (J.A. 99-114.) The West Virginia court ultimately dismissed the action on December 6, 2001, after concluding that Wahi was not entitled to the relief he sought because the peer review process was still ongoing. It declined to "render advisory opinions" or accept Wahi's "speculation" that he would receive an unfair hearing. (J.A. 143, 131-46.)

For a while, discussions between Wahi and CAMC continued after the state court case ended, with both parties setting forth various parameters and details of the conduct of a hearing. Then discussions halted,[9] with the parties never reaching an agreement or conducting or scheduling a hearing. In January 2004, Wahi filed a complaint in the United States District Court for the Southern District of West Virginia.

The complaint alleged numerous state and federal claims, including Anti-Trust violations of the Sherman Act, against CAMC and other defendants.[10]

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[9] As a result of CAMC's September 1999 report to the Board of Medicine, the Board undertook an investigation into Wahi's suspension and ultimately filed a complaint against him in September 2001 to determine whether disciplinary action should be taken regarding Wahi's license to practice medicine. After protracted proceedings, the Board of Medicine ultimately dismissed the charges in November 2003 without reaching a decision on the merits of the allegations. (J.A. 147-180, 254-55, 701.)

[10] The claims against all but one of the other defendants, Dr.

(R. 3.) CAMC filed a motion for summary judgment, which the district court construed as a motion to dismiss pursuant to Rule 12(b)(6). (J.A. 48.) By order dated October 27, 2004, the district court dismissed the Sherman Act claims for failure to allege an effect on interstate commerce, but granted Wahi leave to amend to remedy that omission. (J.A. 59-61.) The district court also dismissed all but one of Wahi's § 1983 claims against CAMC, finding "utterly without merit" Wahi's assertion that CAMC acted "under color of state law" because it reported him to the NPDB. (J.A. 61-62.) Lastly, it dismissed Wahi's state invasion of privacy or wrongful disclosure claim, concluding that "a plain reading of [the HCQIA] means that only the information contained in a report to the [NPDB], and not the mere fact that a report was made, is protected as confidential." (J.A. 63-64.)

Wahi then filed an amended complaint reiterating the claims the district court had not dismissed in its October 2004 order, and amending the Sherman Act claims to include allegations of an effect on interstate commerce. (J.A. 68-93.) Wahi's amended complaint alleged the following claims: (1) Anti-Trust Conspiracy, in violation of the Sherman Act, 15 U.S.C. § 1 (2000); (2) Anti-Trust Monopolization, in violation of the Sherman Act, 15 U.S.C.A. § 2 (West 1997 & Supp.2008); (3) breach of contract and implied covenant of good faith and fair dealing; (4) conspiracy to deny his constitutional right to due process, in violation of 42 U.S.C.A. § 1983 (West 2005); (5) defamation; and (6) violation of his

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Crotty, were subsequently dismissed from the suit, see R. 12 and 88, and are not before us in this appeal.

civil rights under 42 U.S.C.A. § 1981 (West 2005).[11] Wahi also sought a declaration "that the reports made by [CAMC] to the NPDB are invalid and contrary to law," the removal of CAMC's "derogatory reports concerning [Wahi] from the NPDB," the reinstatement of Wahi's hospital privileges, actual and punitive damages, attorneys fees, and costs. (J.A. 92.) Wahi's overarching contention was that CAMC's decisions to suspend him and deny his application for reappointment were taken in bad faith to prevent competition by monopolizing the field of cardiac surgery in the region and to prevent him from practicing medicine. (J.A. 68-92.)

By order dated September 29, 2006, the district court granted motions by CAMC and Dr. Crotty for summary judgment on all counts. *Wahi v. Charleston Area Med. Ctr.*, 453 F.Supp.2d 942 (S.D.W.Va.2006). (J.A. 262-91.) The court held that CAMC qualified for immunity under the HCQIA from all of Wahi's claims for damages. In so doing, it analyzed each of the four components that a professional review action must possess in order to qualify for immunity, as set forth in 42 U.S.C. § 11112(a), and concluded that CAMC fulfilled each requirement. *Id.* at 948-55. (J.A. 266-79.) Regarding the fact that CAMC never held a hearing regarding Wahi's suspension, the district court found

> that the evidence offered by Dr. Wahi is insufficient for a reasonable jury to find that CAMC failed to fulfill its obligations under § 11112(a)(3) by a preponderance of the evidence. The overwhelming evidence is that CAMC acted

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[11] Additional claims were subsequently voluntarily dismissed and are not at issue on appeal. (J.A. 12; R. 61.)

> in an objectively reasonable manner in light of the totality of the circumstances in this case and took sufficient measures to ensure Dr. Wahi received adequate notice of any hearing or meeting that was to occur in the proposed actions against him. The many letters between the parties illustrate the hospital's attempts to set a hearing at Dr. Wahi's request and give him notice of the hearing. Dr. Wahi was represented by counsel throughout the process and in the end, he was informed and fully aware of his rights, the hospital's policies, and the charges and evidence the hospital had against him. The hospital responded promptly when Dr. Wahi requested a hearing be scheduled.

Id. at 954. (J.A. 278.) The district court concluded the HCQIA immunity protected CAMC against Wahi's claims for violations of the Sherman Act, breach of contract,[12] and defamation. *Id.* at 955. (J.A. 279.) Recognizing that the HCQIA does not afford immunity from claims for injunctive relief, the district court dismissed those claims based on its conclusion that "Wahi fail[ed] to make any argument or allege any facts that would entitle him to injunctive relief."[13] *Id.* at 960. (J.A. 289-90). The

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[12] The district court also provided an alternative basis for the granting of summary judgment as to Wahi's breach of contract claim: CAMC complied with the procedures outlined in its Procedures Manual and those required by federal law, and that CAMC's Bylaws did not constitute a contract under West Virginia law, so any violation of the Bylaws could not constitute a breach of contract. *Id.* at 955-56. (J.A. 280-82.)

[13] It also held that Wahi's § 1981 claim was barred by the applicable statute of limitations and also failed on the merits because Wahi had not proven CAMC's race-neutral reason for its actions were pretextual. *Id.* at 957-60. (J.A. 282-88.) Because

district court recognized that the HCQIA does not provide immunity from claims alleging civil rights violations, but granted CAMC summary judgment on Wahi's § 1983 conspiracy to deny due process claim because "Wahi [did] not offer even a scintilla of evidence that there was communication between CAMC and the Board of Medicine beyond that required by law." *Id.* (J.A. 288-89.) Accordingly, the district court awarded summary judgment to CAMC and dismissed Wahi's case with prejudice. *Id.* (J.A. 291.)

Wahi noted a timely appeal, (J.A. 292-93), and we have jurisdiction under 28 U.S.C.A. § 1291 (West 2006).

II.

On appeal, Wahi's primary argument is that the district court erred in holding that CAMC[14] was entitled to immunity under the HCQIA even though CAMC summarily suspended Wahi "without notice or a hearing." Wahi also contends that the district court erred in dismissing his claims seeking injunctive relief because the HCQIA only provides immunity

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Wahi does not challenge the district court's disposition of this claim, it is not before us on appeal. *See* Fed. R.App. P. 28(a)(9)(A); *see also 11126 Baltimore Boulevard, Inc. v. Prince George's County*, 58 F.3d 988, 993 n. 7 (4th Cir. 1995) (en banc) (involving predecessor to Federal Rule of Appellate Procedure 28(a)(9)(A)).

[14] In his opening brief, Wahi states that he "is also appealing the dismissal of Dr. Crotty as a co-defendant," even though he refers to CAMC as the "Appellant." (Br. Appellant 3.) The district court similarly analyzed the claims against CAMC and Dr. Crotty together. We will invoke a similar convention, referring only to CAMC, but including Dr. Crotty in the analysis for the claims Wahi brought against him.

from suits for damages. In addition, Wahi challenges the district court's determination that CAMC was not a state actor and therefore was not amenable to suit under 42 U.S.C.A. § 1983 (2005). Lastly, Wahi asserts the district court erred in dismissing his state law defamation, breach of confidentiality, and breach of contract claims. We address each argument below.

A. HCQIA Immunity

Wahi asserts the district court erred in determining CAMC was entitled to immunity under the HCQIA because CAMC never held a hearing regarding Wahi's suspension, and therefore did not satisfy the requirements for claiming immunity under the Act. (Br. Appellant 18-30; Reply Br. 2-15.) However, we conclude the district court did not err in determining CAMC was entitled to immunity under the particular facts of this case.

The HCQIA provides a "professional review body"[15] with immunity from damages whenever a "professional review action"[16] is taken:

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[15] "The term 'professional review body' means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity." 42 U.S.C.A. § 11151(11) (West 2005).

[16] A "professional review action" is:

> an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C.A. § 11112(a) (West 2005). "A professional review action shall be presumed to have met the preceding standards necessary for [immunity] unless the presumption is rebutted by a preponderance of the evidence." *Id.*

Due to the presumption of immunity under the HCQIA, a court applies an "unconventional standard in determining" whether summary judgment is appropriate-"whether a reasonable jury, viewing all facts in a light most favorable to [Wahi], could conclude that he had shown, by a preponderance of the evidence, that [CAMC's] actions fell outside the scope of section 11112(a)." *Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255, 260 (4th Cir. 2001). In determining whether a health care entity has met these four requirements, the Court applies

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formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action.

42 U.S.C.A. § 11151(9) (West 2005).

an objective test that "looks to the totality of the circumstances" to determine whether the action satisfies the § 11112(a) provisions. *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030 (4th Cir. 1994).

In a footnote in his opening brief, Wahi contends that even though the "primary focus of this appeal is the failure of CAMC to schedule a hearing," as required under subsection 3 of § 11112(a), the "first, second and fourth prongs of the test [for immunity under the HCQIA] were also not met." (Br. Appellant 29 n. 11.) Other than this declarative sentence, Wahi fails to raise any argument to support his claim that the first, second, and fourth prongs of the subsection (a) immunity criteria were not met.[17] Federal Rule of Appellate Procedure 28(a)(9)(A) requires that the argument section of an appellant's opening brief must contain the "appellant's contentions and the reasons for them, with citations to the authorities and parts of the record on which the appellant relies." Because Wahi has failed to comply with the specific dictates of Rule 28(a)(9)(A), we conclude that he has waived his claims as to the first, second, and fourth requirements of the subsection (a) HCQIA immunity test on appeal. *See 11126 Baltimore Boulevard, Inc.*, 58 F.3d at 993 n. 7 (involving predecessor to Federal Rule of Appellate Procedure 28(a)(9)(A)). Accordingly, our review regarding the immunity issue is limited to whether the district court erred in determining that Wahi did not overcome the presumption that CAMC satisfied the requirements of subsection (a)(3).

A health care entity is "deemed to have met the

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[17] Unless otherwise indicated, references to "subsection ---" will refer to subsections of 42 U.S.C. § 11112.

adequate notice and hearing requirement of" § 11112(a)(3) when it satisfies the safe harbor provisions of § 11112(b). Wahi argues that because CAMC failed to follow the provisions of subsection (b), it does not qualify for immunity under the HCQIA. However, as the district court properly recognized, (J.A. 275), following the provisions of subsection (b) is but one way a health care entity can comply with the requirements of subsection (a)(3). While a health care entity is "deemed to have met" the subsection (a)(3) immunity requirements by following the safe harbor provisions of subsection (b), those provisions are not exclusive. "[F]ailure to meet the conditions described [in subsection (b)] shall not, in itself, constitute failure to meet the standards of subsection (a)(3)." § 11112(b)(3). Therefore, Wahi's argument that CAMC is not entitled to immunity, as a matter of law, because it did not comply with all of the provisions in subsection (b), fails under the plain language of the statute.

Wahi next asserts that CAMC is not entitled to immunity because it failed to satisfy the exceptions from immunity carved out in § 11112(c). Wahi contends that since CAMC summarily suspended him for more than 14 days without first finding that he posed an imminent danger to his patients and without conducting a post-suspension investigation, CAMC cannot claim immunity under the HCQIA. Wahi misreads the statute. Subsection (c) sets forth limited circumstances in which a health care entity can act with immunity without satisfying all of the conditions in subsection (a). Subsection (c) provides in pertinent part:

For purposes of section 11111(a) of this title,

> nothing in this section shall be construed as-
>
> (1) requiring the procedures referred to in subsection (a)(3) of this section-
>
> (A) where there is no adverse professional review action taken, or
>
> (B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or
>
> (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

§ 11112(c).

Subsection (c) thus sets out *distinct* ways in which a health care entity can be immune under the HCQIA *without* having complied with the usual requirements for claiming immunity. Wahi would have us read the statute by ignoring this clear purpose and instead find that the HCQIA immunity is barred by failing to meet one of the subsection (c) prongs. To the contrary, subsection (c) presents additional routes to HCQIA immunity beyond that set forth in subsection (a)(3). Although Wahi may be correct that the facts show CAMC cannot assert immunity based on (c)(1) or (c)(2), the only significance is that CAMC must meet the usual standard of qualifying for immunity set forth in

subsection (a)(3).[18]

Under subsection (a)(3), a health care entity seeking HCQIA immunity must act "after adequate notice and hearing procedures are afforded to the physician involved *or* after such other procedures as are fair to the physician under the circumstances." § 11112(a)(3) (emphasis added). Stated in the disjunctive, the statute contemplates two independent avenues by which the subsection (a) immunity prong may be obtained. The first avenue, "adequate notice and hearing procedures," is not at issue in the case at bar. CAMC makes no claim under that prong and the district court did not consider it.

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[18] **[REDACTED]**

What CAMC argues, and the district court held, is that the unique circumstances in this case show that Wahi received "other procedures as are fair to the physician under the circumstances," and entitle CAMC to the HCQIA immunity.

Wahi cites the legislative history of subsection (a)(3) to assert that the "other procedures" undertaken by a health care entity must nonetheless include a hearing. In particular, Wahi relies on this language from the 1986 House Report recommending the adoption of the HCQIA:

> The due process requirement [i.e., subsection (a)(3),] can always be met by the procedures specified in subsection (b).... If other procedures are followed, but are not precisely of the character spelled out in [subsection (b)], the test of "adequacy" may still be met under other prevailing law. The Committee is aware, for example, that some courts have already carefully spelled out different requirements for certain professional review activities or actions, such as procedures for decisions regarding applicants for clinical privileges at a hospital. In those situations, compliance with applicable law should satisfy the "adequacy" requirement even where such activities or actions require different or fewer due process rights than the ones specified under [subsection (b)]. In any case, it is the Committee's intent that physicians receive fair and unbiased review to protect their reputations and medical practices.

H.R.Rep. No. 99-903, at 10-11 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6393. Nothing in this legislative history alters the conclusion that a health

care entity can satisfy subsection (a)(3) without providing a formal hearing, as contemplated in the safe harbor provisions, depending on the circumstances of a particular case. Rather, Congress' intent-and that expressed by the plain language of the statute-is that a physician be afforded adequate and fair "procedures" with regard to professional review actions, which could be something other than a formal hearing in some circumstances. If this were not so, Congress would have no reason to have included the "other procedures appropriate ... under the circumstances" language contained in the statute in contrast to the specific "notice and hearing" language.

Wahi also contends that CAMC's failure to follow some of the procedures outlined in its Bylaws and Procedures Manual proves CAMC did not satisfy subsection (a)(3) under the alternative prong. However, as the Court of Appeals for the Fifth Circuit recently observed,

> HCQIA immunity is not coextensive with compliance with an individual hospital's bylaws. Rather, the statute imposes a uniform set of national standards. Provided that a peer review action ... complies with those standards, a failure to comply with hospital bylaws does not defeat a peer reviewer's right to HCQIA immunity from damages.

Poliner v. Tex. Health Sys., 537 F.3d 368, 380-81 (5th Cir. 2008); *see also Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 469-71 (6th Cir. 2003). Nothing in the subsection (a)(3) phrase "such other procedures as are fair ... under the circumstances" mandates by-law compliance as the

sine qua non for immunity, although from a practical standpoint, by-law compliance may often be proof of such procedures in many cases.

Having concluded that CAMC was not required to hold a formal hearing as a mandatory condition precedent to satisfying subsection (a)(3), we now examine whether the district court properly determined CAMC provided Wahi with "such other procedures as are fair ... under the circumstances." We begin that review by underscoring the unique procedural posture upon which summary judgment for a health care entity is measured under the HCQIA, as the district court properly summarized:

> In applying the test outlined in § 11112(a), we begin with the presumption that the hospital has met the necessary standards for immunity unless this presumption is rebutted by a preponderance of the evidence. § 11112(a). The applicable standard is one of objective reasonableness, viewed in light of the totality of the circumstances. *Freilich[v. Upper Chesapeake Health, Inc.*, 313 F.3d 205,] 212 [(4th Cir. 2002)] (quoting *Imperial v. Suburban [Hosp. Ass'n]*, 37 F.3d 1026, 1030 (4th Cir. 1994)). Reasonableness standards have been consistently upheld in the context of qualified immunity. *Freilich*, 313 F.3d at 213.

Wahi, 453 F.Supp.2d at 950. (J.A. 270.) We find no error in the district court's determination that Wahi failed to rebut the presumption that CAMC's actions satisfied the statutory requirement when the totality of the circumstances are viewed in an objectively reasonable manner.

[REDACTED] informed Wahi of the allegations from the Credentials Committee by letter dated July 16 and further discussed them in a meeting with him on July 17. (J.A. 575-77.) Moreover, Wahi apparently learned of the unauthorized surgery allegation against him even prior to [REDACTED]'s letter because on July 15, he wrote to [REDACTED] stating he understood questions had arisen regarding his decision to perform the procedure, explaining his decision to perform the contested procedure, and setting forth why he believed it fell within his clinical privileges. (J.A. 721-28.) Although [REDACTED]'s July 16 letter does not mention a possible suspension, it does state that CAMC would be investigating the claims that Wahi had again exceeded his authority under his provisional privileges and not complied with the CAMC Bylaws when he failed to notify CAMC that he had relinquished his privileges at another hospital. Wahi had previously been suspended at least three times for violation of his privileges and was not unaware of the consequences.

[REDACTED] also informed Wahi that he should respond in writing as soon as possible and address his reappointment before the Credentials Committee at the August 3, 1999 hearing, (J.A. 576), which was rescheduled for August 17 at Wahi's request. Over the next two weeks, Wahi wrote to [REDACTED] and [REDACTED] several times, addressing the charges in writing, and providing documents supporting his position that he had not violated the conditions of his clinical privileges. He also requested access to certain records prior to or during the Credentials Committee meeting. (J.A. 730, 731, 732-41, and 742.) The record shows that CAMC provided Wahi with notice of the

most recent allegations against him, and an opportunity to respond to those allegations. CAMC complied with its Procedures Manual in this regard.

CAMC suspended Wahi's medical privileges by a letter dated July 30, 1999 from **[REDACTED],** which recited the "best interests of patient care" as the reason for the action. (J.A. 586.) However, the record does not support Wahi's contention that CAMC did not inform him more specifically of the reasons for his suspension. On July 30, **[REDACTED]** and **[REDACTED]** met with Wahi to inform him of the suspension pending the Credentials Committee's review of his application for reappointment. **[REDACTED]**'s memorandum of that meeting recites that they informed Wahi that the Credentials Committee and Board of Trustees both recommended he be suspended. **[REDACTED]** cited Wahi's "inability to follow procedural guidelines outlined by the Committee and the Board of Trustees which ensures adequate care and safety of patients," and also told Wahi that when he met with the Credentials Committee, he should "be prepared to defend his lack of adherence to the limitations on his privileges as well as his absence of notification of suspension from St. Francis [Hospital]."[19] (J.A. 965.) The suspension letter reiterated the rights due Wahi under Article III of the Procedures Manual for a hearing to challenge that action, and attached a copy for his use.

The Credentials Committee then afforded Wahi, by letter of August 13, 1999, the opportunity to

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[19] **[REDACTED]** and **[REDACTED]** also agreed that Wahi could continue treating two patients "currently in house" and that care of all of Wahi's patients would be transferred to another physician or discharged by August 1, 1999. (J.A. 965.)

review the file for the August 17 meeting for the "timeline of events surrounding [his] privileges" at CAMC. The letter also emphasized to Wahi that

> This meeting is your opportunity to present the Committee with additional information that is pertinent to its evaluation of your ethical behavior, clinical competence and clinical judgment in the treatment of patients; compliance with Hospital policies and the Medical Staff Bylaws and Rules and Regulations; behavior in the hospital, your cooperation with medical and Hospital personnel as it relates to patient care or the orderly operation of hospital, and your general attitude toward patients, the Hospital and its personnel; use of the Hospital facilities for your patients; your physical and mental health; your capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment activities or other reasonable indicators of continuing qualifications; your satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital or applicable accreditation agencies; and other relevant findings from CAMC's and the Medical Staff's quality assurance activities.

(J.A. 752.) Copies of relevant portions of CAMC's Procedures Manual were attached to the letter. (J.A. 752-57.) A separate letter informed Wahi how the meeting would be conducted, and set out Wahi's rights regarding the meeting. (J.A. 719-20.)

The Credentials Committee met on August 17, 1999. Wahi appeared before it and presented his case. The Committee concluded it "was unable to identify

evidence that Dr. Wahi's clinical competence [and] professional judgment ... are sufficient to recommend ... that he be reappointed to the Medical Staff."[20] (J.A. 645-46.) In particular, the Committee cited the following

- Failure to comply with and repeated violation of clinical privileges (§ 3.7 of the Bylaws), including:
- Failure to obtain a proctor when required to do so;
- Failure to obtain a second opinion when required to do so;
- Performance of an operative procedure for which he did not have privileges.
- Marginal indications for operative procedures;
- Poor decision-making in the care of some patients;
- Multiple incident reports surrounding bizarre professional behavior and inappropriate personal behavior among nursing staff;
- Failure to comply with responsibilities set forth in the CAMC Bylaws, including providing proper quality of care (§ 3.2), maintaining proper medical records (§ 3.3), and notifying CAMC of the loss of clinical privileges at any other hospital (§ 3.6); and
- Failure to keep a current, complete, and timely record of patient care (§§ 2.1 and 2.7 of the

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[20] Denial of reappointment is a NPDB-reportable event. *See* 42 U.S.C. § 11133(a) (requiring health care entities to report "professional review action[s] that adversely affect[ ] the clinical privileges of a physician for a period longer than 30 days").

Medical Staff Rules and Regulations) (J.A. 550, 552-53).

(J.A. 645.)

On August 26, 1999, Wahi received the Credentials Committee report and was once again notified of the rights provided in Article III and that he had 30 days to request a hearing.[21] (J.A. 647.) The letter also informed Wahi his suspension remained in effect until the CAMC Board of Trustees acted on his reappointment. (J.A. 647.) On September 8, 1999, Wahi, by counsel, timely requested a hearing as well as a witness list and a number of specified documents. (J.A. 648-53.)

On October 18, 1999, CAMC notified Wahi of the members of the hearing panel and asked Wahi to "work with the presiding officer to schedule and conduct the hearing in accordance with ... Article III," and again forwarded Wahi the Procedures Manual.[22] (J.A. 654-55, 699-700.) CAMC did not give Wahi a specific witness list,[23] but afforded his counsel access

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[21] Article III of the Procedures Manual set forth Wahi's right to a hearing based on both the summary suspension and the Credentials Committee's recommendation to deny Wahi's application for reappointment. (See Procedures Manual 2.3.4.2, 2.4.3, 3.1; J.A. 484-87.)

[22] The Procedures Manual stated that once a hearing is requested, the President of CAMC "shall schedule the hearing and shall give notice of its time, place and date ... to the person who requested the hearing. The hearing shall begin as soon as practicable, considering the schedules and availability of all concerned, provided that [it] shall not begin without at least thirty days notice." (Procedures Manual 3.6; J.A. 489.)

[23] Section 3.7 of the Procedures Manual states that CAMC should have provided a list of witnesses to Wahi "within ten

to some of the files requested in the September 8, 1999 letter. CAMC repeatedly requested that Wahi provide available dates for his hearing because "the hearing will take a number of days" and it was important to "select dates well enough in advance that all involved parties can clear their schedules." (J.A. 776.) In over 8 years since his request for a hearing, Wahi has yet to provide CAMC with any dates when he would be available for a hearing.

During the following year, the parties negotiated over how the hearing would be conducted. Wahi objected to the composition of the panel, its presiding officer,[24] and the use of any incident or discipline during his medical practice at CAMC that he did not address at the August 17, 1999 Credentials Committee meeting. And while CAMC had opened many of its files to Wahi and his counsel, some items Wahi had requested had not been disclosed due to privacy disagreements, which had not been resolved. The parties also attempted to negotiate a resolution of the matter, including withdrawing Wahi's suspension based on a written statement of the basis for CAMC's actions. However, the parties were unable to reach an agreement. (J.A. 760-83, 118-30.)

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days" of his request, and that the witness list could be supplemented or amended in the discretion of the presiding officer of the hearing, provided that notice of the change has been given. (J.A. 489.)

[24] The Procedures Manual provides that the President of CAMC "shall appoint a panel of not less than three members, none of whom are in direct competition with the individual who requested the hearing," after considering the recommendations of the Chief of Staff and the Chairman of the Board. (Procedures Manual 3.8; J.A. 489.)

On November 30, 2000, Wahi filed an action in the West Virginia state court to enjoin his requested hearing unless CAMC met his pre-conditions. Wahi asked the state court to order, inter alia, that his method of selection for the hearing panel be used, that no matters of Wahi's medical practice at CAMC be considered at the hearing except those mentioned in **[REDACTED]'s** July 30, 1999 letter, and that the court maintain "jurisdiction over the administrative hearing." (J.A. 99, 112, 99-114.)

The state court rejected Wahi's arguments and dismissed the complaint, stating Wahi's arguments were speculative and "[i]t would be premature for the Court to make any determination as to whether or not the notice given to Dr. Wahi satisfies the 'fair procedures' requirement." (J.A. 141.) Furthermore, the court noted that the composition of the hearing panel was in conformity with CAMC's Procedures Manual, and that any objections about the hearing panel or the evidence to be considered should be raised before the hearing panel. The court entered its final order of dismissal on December 6, 2001.

In the meantime, the West Virginia Board of Medicine filed a complaint against Wahi on September 10, 2001, and set a hearing "to determine whether disciplinary action should be taken ... against Dr. Wahi's license to practice medicine." (J.A. 149.) Wahi and the Board of Medicine engaged in protracted litigation, which included Wahi's unsuccessful attempt to halt the proceedings by seeking a writ of prohibition against the Board of Medicine from the Supreme Court of Appeals of West Virginia. On November 10, 2003, the proceedings were dismissed, without a final disposition on the

merits of the allegations. (J.A. 147-175, 701.) Wahi made no effort during this time period to pursue a hearing at CAMC. While CAMC argues this was a deliberate choice by Wahi to prevent a hearing that would create a record that could affect the Board of Medicine proceedings, the district court made no finding in that regard, CAMC assigns no error to the lack of a finding, and we therefore do not consider it. The next action in time was the filing of Wahi's complaint in the district court.

Lastly, in considering whether the procedures provided by the health care entity are fair "under the circumstances," the July 1999 allegations against Wahi cannot be considered in a vacuum. These allegations were simply the latest in Wahi's tumultuous history with CAMC, as the August 26, 1999 Credentials Committee letter set forth. Since his reappointment in 1995, Wahi had been the subject of numerous reports and complaints calling his professional competence and conduct into question. The record shows that these complaints arose from a multitude of discrete incidents, were made by different individuals, and were known to Wahi. After all Wahi had been through the suspension process previously at CAMC, including the prior reports to the NPDB. CAMC investigated and imposed restrictions, including temporary suspensions, as a result of those investigations. Wahi was aware of the consequences for failing to abide by the Bylaws and Procedures Manual. He was not a first-time offender who was unfamiliar with the responsibilities of his position at CAMC or the consequences for his failures in July 1999. (J.A. 130-31, 248-53, 339-97, 496-571.)

While CAMC's path to immunity in this case is not a recommended model, it must be evaluated considering all the events which transpired, not just those Wahi views as favorable to him. Had CAMC simply set a prompt hearing, whatever Wahi's objections and efforts to stop it, CAMC may have been within its rights to do so and may have met the first prong of subsection (a)(3). Similarly, CAMC should have followed its Bylaws and the Procedures Manual, and provided Wahi a witness list, even if it had to be later supplemented. However, these failures by CAMC, when viewed in the totality of the circumstances against a measuring stick of objective reasonableness, do not show Wahi met his burden of proof to rebut the presumption of immunity under the HCQIA. Wahi was on notice of the many charges against him, including the detailed Credentials Committee report of August 26, 1999. He was repeatedly notified of his rights and given multiple copies of documents explaining these rights. He was repeatedly asked for dates for a hearing. While CAMC attempted to accord Wahi a hearing in conformity with the Procedures Manual, Wahi seemed more intent on forestalling a hearing than having one.

Had Wahi proceeded to a hearing, any complaint about the inadequacy of notice, defective witness list or discovery, the composition of the hearing panel, the conduct of the hearing, or other relevant issues could have been addressed and subjected to judicial review. In the face of Wahi's recalcitrance, it is at the least disingenuous to now claim his right to a hearing was infringed when he has done all he could do *not* to have a hearing. Viewing the totality of these circumstances in an objectively reasonable manner,

we cannot conclude that the district court erred in determining Wahi failed to rebut the presumption that CAMC afforded him "other procedures as are fair to the physician under the circumstances." We therefore affirm the district court's holding that CAMC is entitled to immunity under the HCQIA.

B. Injunctive Relief

Wahi also contends the district court erred in awarding summary judgment [25] as to his claims for injunctive relief because "[a]lthough the HCQIA immunize[d] [CAMC and Dr. Crotty] from claims for monetary damages, that statutory immunity does not apply to injunctive relief." (Br. Appellant 25.) He asserts he has satisfied the requirements for obtaining an injunction requiring CAMC to provide him a hearing and remove his name from the NPDB list because he cannot acquire gainful employment so long as his name is on the NPDB list, monetary damages will not restore his ability to practice, and the public possesses a strong interest in ensuring hospitals abide by the law. (Br. Appellant 25-26; Reply Br. 17-20.)

The HCQIA only provides immunity from suits

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[25] We review the district court's grant of summary judgment on this issue de novo. *Hill v. Lockheed Martin Logistics Mgmt., Inc.*, 354 F.3d 277, 283 (4th Cir. 2004) (en banc). "Summary judgment is appropriate if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Id.* (internal quotation marks omitted). We construe the evidence in the light most favorable to Wahi, the party opposing the Appellees' motion, and draw all reasonable inferences in his favor. *See id.*

for damages. 42 U.S.C. § 11111(a)(1); *see Imperial*, 37 F.3d at 1030-31. The district court expressly recognized this limitation, and it did not base its decision that Wahi was not entitled to injunctive relief on CAMC's immunity under the HCQIA. (J.A. 289-90.) Instead, it concluded Wahi "fail[ed] to make any argument or allege any facts that would entitle him to injunctive relief." *Wahi*, 453 F.Supp.2d at 960. (J.A. 289-90.)

The district court did not err in this determination. In order to pursue injunctive relief to redress his Anti-Trust, breach of contract, and defamation claims, Wahi must have a viable claim that CAMC committed a wrong.

> [A] remedy must be tailored to a violation [and] the nature of the violation determines the scope of the remedy. Remedies, in other words, do not exist in the abstract; rather, they flow from and are the consequence of some wrong. At its most basic, this principle limits the reach of judicial decrees to parties found liable for a legal violation.

See Bacon v. City of Richmond, 475 F.3d 633, 638 (4th Cir. 2007) (quoting *Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 16, 91 S.Ct. 1267, 28 L.Ed.2d 554 (1971)) (internal quotation marks and citations omitted). Wahi has not made the requisite showing for any of the claims for which the district court determined the HCQIA immunity applied. The district court provided non-HCQIA-based reasons for awarding CAMC summary judgment on Wahi's breach of contract and defamation claims, which Wahi has also appealed, and which we discuss below.

Lastly, even if Wahi succeeded on the merits of his Anti-Trust claims, he would not be entitled to the injunctive relief he sought in his amended complaint. Wahi's amended complaint asked for an injunction directing CAMC "to remove its derogatory reports concerning Dr. Wahi from the NPDB" and "to reinstate Dr. Wahi's hospital privileges." (J.A. 92.) This relief is not connected to any alleged acts of anti-competitive behavior by CAMC.

C. State Actor

Wahi asserts the district court erred in determining CAMC was not a state actor, as that term is contemplated under § 1983, and therefore not amenable to suit under that statute.[26] (Br. Appellant

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[26] As noted, the district court dismissed all but one of Wahi's § 1983 claims in its October 27, 2004 order granting CAMC's motions under Rule 12(b)(6). Therefore, we conduct a de novo review of the district court's decision, *Mylan Labs., Inc. v. Matkari*, 7 F.3d 1130, 1134 (4th Cir. 1993), accepting all allegations in Wahi's complaint as true. *Republican Party v. Martin*, 980 F.2d 943, 952 (4th Cir. 1992). To survive a Rule 12(b)(6) motion, "[f]actual allegations must be enough to raise a right to relief above the speculative level" and have "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 127 S.Ct. 1955, 1965, 1974, 167 L.Ed.2d 929 (2007). Moreover, the court "need not accept the [plaintiff's] legal conclusions drawn from the facts," nor need it "accept as true unwarranted inferences, unreasonable conclusions, or arguments." *Kloth v. Microsoft Corp.*, 444 F.3d 312, 319 (4th Cir. 2006) (internal quotation marks omitted).

Wahi challenges the district court's determination that CAMC was not itself a state actor, but he makes no argument related to the September 29, 2006 order dismissing his conspiracy-based § 1983 claim based on a failure to show any evidence that CAMC conspired with the state Board of Medicine. Accordingly, our review is limited to the § 1983 claims dismissed in the district court's October 2004 order.

12-15; Reply Br. 21-22.) To state a claim under § 1983, a plaintiff must aver that a person acting under color of state law deprived him of a constitutional right or a right conferred by a law of the United States. *See Dowe v. Total Action Against Poverty,* 145 F.3d 653, 658 (4th Cir. 1998). "Like the state-action requirement of the Fourteenth Amendment, the under-color-of-state-law element of § 1983 excludes from its reach 'merely private conduct, no matter how discriminatory or wrongful.' " *Am. Mfrs. Mut. Ins. Co. v. Sullivan,* 526 U.S. 40, 50, 119 S.Ct. 977, 143 L.Ed.2d 130 (1999). Consequently, "[t]he person charged must either be a state actor or have a sufficiently close relationship with state actors such that a court would conclude that the non-state actor is engaged in the state's actions." *DeBauche v. Trani,* 191 F.3d 499, 506 (4th Cir. 1999). "[P]rivate activity will generally not be deemed 'state action' unless the state has so dominated such activity as to convert it to state action: 'Mere approval of or acquiescence in the initiatives of a private party' is insufficient." *Id.* at 507; *see also Dowe,* 145 F.3d at 659.

To support his argument, Wahi contends that by reporting him to the NPDB, CAMC "essentially decredentialed" him, a power that is "reserved exclusively to state government" and turns CAMC's conduct into state action. (Br. Appellant 14, 12-15; Reply Br. 21-22.) We previously examined, and rejected, a similar argument in *Modaber v. Culpeper Memorial Hospital, Inc.,* 674 F.2d 1023 (4th Cir. 1982). In that case, we held that a hospital's compliance with a Virginia statute requiring the hospital to report the revocation of privileges did not "authorize state officials to make privileges decisions,

or to set forth directions governing the outcome of such decisions, or attach consequences to their results." *Id.* at 1027 (footnotes omitted). For these reasons, we held the Virginia statute did not "involve the 'exercise by a private entity of powers traditionally exclusively reserved to the State.' " *Id.* at 1027 (quoting *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 352, 95 S.Ct. 449, 42 L.Ed.2d 477 (1974)); *see also Freilich,* 313 F.3d at 214 n. 3 (holding private hospital was not a state actor because the state played no role in the "actual decision as to whether or not to terminate or reappoint any particular physician").

Similarly, the federal statute requiring a hospital to report credentialing decisions to the NPDB does not authorize state officials to make any decisions regarding a physician's hospital privileges, nor does it direct the hospital's actions thereafter. Instead, it simply requires hospitals to report to the NPDB adverse professional review action "affect[ing] the clinical privileges of a physician." *See* 42 U.S.C.A. § 11133. Accordingly, we find that the statute does not confer to CAMC powers traditionally reserved to the state, and it does not turn CAMC's actions into state action for a § 1983 claim.[27]

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[27] In addition, Wahi also cites CAMC's "extensive programs and merger with" West Virginia University (a public institution), CAMC's status as the "largest hospital," in the state, and a comment made in a CAMC Foundation book characterizing CAMC as an "entirely public institution." (Br. Appellant 12-15; Reply Br. 21-22.) These arguments were raised for the first time on appeal and therefore we will not consider them. *See Williams v. Prof. Transp. Inc.*, 294 F.3d 607, 614 (4th Cir. 2002) (stating that issues raised for the first time on appeal "are generally not considered absent exceptional circumstances"). (Compare J.A. 28-30, with R. 24 pp. 13-14.)

D. Defamation Claim

Wahi contends that the district court erred in awarding summary judgment on his defamation claim.[28] He specifically argues on appeal that "Wahi was defamed when Dr. Crotty intentionally disclosed to the local media that CAMC had reported him to the NPDB." (Br. Appellant 34.) This argument, however, was not presented to the district court and appears for the first time on appeal. Wahi's amended complaint states as the sole basis for his defamation claim that CAMC's "amended reports published by [CAMC] to the NPDB on June 10, 2003, were false and defamatory, *per se*." Wahi contends CAMC published the "defamatory reports to the NPDB with reckless disregard for the truth" and therefore "is liable to [Wahi] for defamation." (J.A. 88.) This is the argument presented and ruled upon by the district court when determining whether HCQIA immunity barred Wahi from pursuing the claim. (See R. 98, p. 75.)

Wahi's defamation claim on appeal is therefore not the one presented in his amended complaint. We have previously held, along with the Fifth, Sixth, Seventh, and Eleventh Circuits, that a plaintiff may not raise new claims after discovery has begun without amending his complaint. *Barclay White Skanska, Inc. v. Battelle Mem'l Inst.*, 262 Fed.Appx. 556, 563 (4th Cir. 2008) (unpublished) (citing *Tucker v. Union of Needletrades, Indus., & Textile Employees*, 407 F.3d 784, 788 (6th Cir. 2005); *Gilmour v. Gates, McDonald & Co.*, 382 F.3d 1312,

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[28] We review this claim de novo, under the traditional principles set forth *supra*, note 25.

1315 (11th Cir. 2004); *Shanahan v. City of Chicago,* 82 F.3d 776, 781 (7th Cir. 1996); and *Fisher v. Metro. Life Ins. Co.,* 895 F.2d 1073, 1078 (5th Cir. 1990)). Wahi never amended his complaint to change his existing defamation claim or add a new defamation claim based on Dr. Crotty's statement to the media. Therefore, we will not consider the claim for the first time on appeal. *See United States v. Evans,* 404 F.3d 227, 236 n. 5 (4th Cir. 2005) (stating that a party who "failed to raise [an] argument before the district court ... has ... waived it on appeal"). Furthermore, because Wahi did not argue his claim of defamation based on the filing of the NPDB report on appeal, that claim is abandoned. *See 11126 Baltimore Boulevard, Inc.,* 58 F.3d at 993 n. 7 (issue waived when not argued on appeal).

E. Breach of Contract Claim

As an alternative basis for awarding summary judgment on Wahi's state law breach of contract claim, the district court concluded CAMC's Bylaws did not constitute a contract between CAMC and Wahi. (J.A. 280-82.) Wahi asserts the district court erred because, under West Virginia law, a hospital's bylaws constitute a contract between the physician and the hospital when a physician is accused of misconduct. Citing *Kessel v. Monongalia County Gen. Hosp. Co.,* 215 W.Va. 609, 600 S.E.2d 321 (W.Va.2004), Wahi contends that because a hospital is "bound" to afford a physician the procedures set forth in its bylaws, "noncompliance with those provisions compels the conclusion that CAMC breached [its] contract" with Wahi. (Br. Appellant 37-39.) We disagree.

Wahi's argument does not properly follow the

West Virginia Supreme Court of Appeals' analysis in *Kessel*. The court clearly rejected the argument that the hospital's medical staff bylaws constituted a contract between the plaintiffs and the hospital, which the hospital allegedly breached. *Id.* at 326.

> [T]he essential element of valuable consideration is absent. This Court has held that the doing by one of that which he is already legally bound to do is not a valuable consideration for a promise made to him, since it gives to the promisor nothing more than that to which the latter is already entitled.... Because the hospital was already bound by [state] law to approve the bylaws of the medical staff, and the medical staff was bound to initiate and adopt bylaws, neither party conferred on the other any more than what the law already required. Thus, we conclude that the medical staff bylaws do not constitute a contract [absent express language to the contrary].

Id. (internal quotation marks and alterations omitted). While a hospital may be required to follow its by-laws as a due process component, there is no contractual relationship unless the by-laws specifically so provide. *Id.* at 327. There was no such provision in *Kessel*, and there is none in the case at bar. Whatever due process entitlement Wahi may claim by virtue of the CAMC by-laws, his arguments are subsumed by the foregoing analysis of his civil rights claims, which failed.

Accordingly, we hold the district court did not err in awarding CAMC summary judgment on Wahi's breach of contract claim.

F. Breach of Confidentiality

Wahi's last argument is that the district court erred in dismissing his state law "breach of confidentiality" claim because 45 C.F.R. § 60.13 prohibited CAMC from disclosing to the local news media the fact that it had reported Wahi to the NPDB.[29], [30] Br. Appellant 35-37.)

45 C.F.R. § 60.13 states, in relevant part:

> Information reported to the [NPDB] is considered confidential and shall not be disclosed outside the Department of Health and Human Services.... Persons and entities which receive information from the [NPDB] either directly or from another party must use it solely with respect to the purpose for which it was provided....

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[29] As noted, the district court disposed of Wahi's claim in its October 2004 order granting CAMC's Rule 12(b)(6) motion. Accordingly, we review the district court's decision *de novo*. *See supra* note 26.

[30] CAMC responds that we should not consider Wahi's argument because Wahi's complaint asserted "invasion of privacy," and not "breach of confidentiality," which are two separate torts under West Virginia law. (Br. Appellee 39-40.)

Wahi's complaint appears to merge an allegation of "invasion of privacy, ... or in the alternative, a wrongful disclosure of private facts." Wahi specifically alleges CAMC "violated the confidentiality of reports to the NPDB" by disclosing to the local media the fact that it had reported Wahi to the NPDB. (J.A. 38-39.) The district court identified the claim as one for Wahi's "inva[sion of] privacy, or in the alternative, wrongful[ ] disclos[ure of] private facts." (J.A. 63.) Although Wahi's complaint could have been much clearer in setting out a cause of action, we find that it was at least sufficient for him to have preserved the issue raised on appeal.

> Any person who violates [the above provision] shall be subject to a civil money penalty of up to $10,000 for each violation.

We find no error in the district court's conclusion that Wahi failed to allege that CAMC's conduct constituted a breach of confidentiality. Section 60.13 guarantees the confidentiality of "[i]nformation reported to" the NPDB and specifically limits the actions of individuals who "receive information *from*" an NPDB report. *Id.* (emphasis added). It therefore does not prevent the entity who reported NPDB from disclosing the mere fact that a report was filed. Accordingly, the district court did not err in granting CAMC's Rule 12(b)(6) motion as to this claim.

III.

For the foregoing reasons, we affirm the judgment of the district court.

AFFIRMED

APPENDIX B

FILED: May 8, 2009

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 06-2162
(2:04-cv-00019)

RAKESH WAHI,

Plaintiff - Appellant

v.

CHARLESTON AREA MEDICAL CENTER, INCORPORATED, A West Virginia Corporation; GLENN CROTTY; JOHN DOES I-X,

Defendants - Appellees

and

JANE DOE NUMBERS 1 THROUGH 10; JAMAL KAHN; H. RASHID; K. C. LEE; ANDREW VAUGHN; JOHN L. CHAPMAN,

Defendants

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INCORPORATED,

Amicus Supporting Appellant

O R D E R

The Court denies the petition for rehearing and rehearing en banc. No judge requested a poll under Fed. R. App. P. 35 on the petition for rehearing en banc.

Entered at the direction of the panel: Judge Gregory, Judge Agee and Judge Smith.

For the Court

/s/ Patricia S. Connor, Clerk

APPENDIX C

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHARLESTON DIVISION

Civil Action No. 2:04-cv-00019

Rakesh WAHI, M.D.,

Plaintiff,

v.

CHARLESTON AREA MEDICAL CENTER, et al.,

Defendants.

ORDER

Pending before the court are the defendants' Motions for Summary Judgment [Docket 75, Docket 79, and Docket 81]. After a thorough review of the pending motions and responses, the court **FINDS** for the defendants and **GRANTS** their summary judgment motions on all counts.

I. BACKGROUND

A. Factual Summary

The plaintiff, Rakesh Wahi, M.D. (Dr. Wahi), has been licensed to practice medicine in West Virginia since 1993. He specializes in cardiovascular, thoracic and general surgical procedures. In January of 1993, Dr. Wahi joined the staff of the defendant Charleston Area Medical Center (CAMC), and in July of 1993 he was promoted from the defendant's probationary staff to provisional staff. CAMC is a private entity incorporated in West Virginia.

In June of 1994, Dr. Wahi started his own practice at CAMC, and also began exploring the

possibility of associating himself with a separate medical group in Beckley, WV, called the "Medsurg Group." According to Dr. Wahi, CAMC then began taking various steps to restrict the plaintiff's ability to practice medicine and to prevent the plaintiff from competing with CAMC. Between 1995 and 1999 Dr. Wahi was the subject of several peer review investigations concerning his performance as a physician. The investigations were mainly conducted internally, but at least one review was conducted by an external committee. Although the reasoning behind and validity of the investigations, as well as, the outcomes remain a point of contention and disagreement between the parties, the reviews did result in various restrictions and suspensions being placed on Dr. Wahi's privileges prior to 1999. As a result of these investigations, negative reports were sent to the National Practitioner's Data Bank (Data Bank).

The Data Bank is a national clearinghouse established pursuant to the Health Care Quality Improvement Act of 1986 (HCQIA). *See* 42 U.S.C. §§ 11133-11134 (2004). Under the HCQIA, health care entities may qualify for immunity from civil liability for certain actions if they report information to the Data Bank following "a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days." *Id.* § 11133(1)(A). According to Congress, the purpose of the Data Bank and reporting incentives is "to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." *Id.* § 11101(2). Reported information must include the physician's name and a description

of the reasons for the adverse action. *Id.* § 11133(3)(A) and (B).

According to Dr. Wahi, negative reports were made about him to the Data Bank by CAMC on November 25, 1996; December 6, 1996; December 24, 1997; March 22, 1999; and September 13, 1999. Based on CAMC's reports to the Data Bank, the West Virginia Board of Medicine (Board of Medicine) investigated Dr. Wahi and brought charges against him on three separate occasions. The plaintiff alleges that the defendant CAMC worked closely with the Board of Medicine to bring these charges and attempted to deprive him of his license to practice medicine in West Virginia. The Board of Medicine dismissed the last charges against Dr. Wahi on November 10, 2003.

The situation between CAMC and Dr. Wahi culminated in July 1999, when the credentials committee withdrew its recommendation that Dr. Wahi's medical staff privileges at CAMC be renewed. The committee's decision was followed by an investigation which resulted in the summary suspension of Dr. Wahi's medical staff privileges at CAMC. However, during the month of July 1999, there were numerous communications between CAMC and Dr. Wahi, in which CAMC notified Dr. Wahi of the allegations, the general nature of evidence, the possible adverse recommendations that the committee was considering, in addition to Dr. Wahi's rights under CAMC medical staff bylaws. In fact, the letters sent from CAMC to Dr. Wahi often included attachments of the relevant portions of the bylaws.

At some point during the process, either before or

after the suspension of his medical privileges at CAMC Dr. Wahi obtained counsel. Following his suspension, Dr. Wahi, via counsel, requested a hearing pursuant to the hospital's bylaws. However, a hearing has never been held. Dr. Wahi alleges that a hearing was never set because CAMC failed to meet its burden of setting a hearing date. CAMC, on the other hand, alleges that a hearing was never scheduled because Dr. Wahi refused to agree to the parameters of any proposed hearing. Ultimately, Dr. Wahi alleges that he has been denied a fair hearing and that the adverse professional review actions were taken pursuant to a conspiracy by the defendants to monopolize thoracic and cardiovascular medicine and surgery in the Charleston, Beckley, Bluefield, and Parkersburg area of West Virginia.

B. Procedural History

Dr. Wahi filed an eleven-count Amended Complaint against CAMC and several other defendants, both named and unnamed. Dr. Wahi claimed that the defendants: 1) engaged in an antitrust conspiracy under the Sherman Act (15 U.S.C. § 1); 2) engaged in antitrust monopolization under the Sherman Act (15 U.S.C. § 2); 3) violated his Fifth and Fourteenth Amendment Due Process rights; 4) retaliated against him in violation of his First Amendment rights; 5) breached the contract between CAMC and Dr. Wahi; 6) conspired to deny him Due Process in violation of his rights under the Fifth and Fourteenth Amendments; 7) defamed him by reporting him to the Data Bank; 8) invaded his privacy and disclosed confidential information; 9) violated his civil rights under 42 U.S.C. § 1981; 10) conspired to obstruct justice and deny equal protection in violation of 42 U.S.C. § 1985; and 11)

neglected to prevent the conspiracy alleged in Count 10 in violation of 42 U.S.C. § 1986. Based on these claims, Dr. Wahi requests injunctive relief, actual damages, and punitive damages.

In response to Dr. Wahi's claims, the defendants moved to dismiss the Complaint for failure to state a claim upon which relief can be granted. In an opinion issued October 27, 2004, this court dismissed counts one and two without prejudice and granted plaintiff leave to amend the complaint to allege an impact on interstate commerce; and this court also dismissed counts three, four, and eight for failure to state a claim upon which relief can be granted. The court then ordered the parties to engage in limited discovery and brief the court on whether defendants are entitled to immunity from civil liability under the HCQIA for all claims except civil rights claims; and whether any issues of material fact exists regarding claims alleged in Counts Five, Six, Nine, Ten and Eleven.

An amended complaint was filed and the counts were renumbered as follows: 1) antitrust conspiracy under the Sherman Act (15 U.S.C. § 1); 2) antitrust monopolization under the Sherman Act (15 U.S.C. § 2); 3) breach of contract between CAMC and Dr. Wahi; 4) conspiracy to deny Due Process in violation of the Fifth and Fourteenth Amendments (42 U.S.C. § 1983); 5) defamation; 6) violation of civil rights under 42 U.S.C. § 1981; 7) conspiracy to obstruct justice and deny equal protection in violation of 42 U.S.C. § 1985; and 8) neglect to prevent the conspiracy alleged in Count 7 in violation of 42 U.S.C. § 1986.

Thereafter, Dr. Wahi voluntarily dismissed all

defendants except CAMC, Dr. Crotty, and Dr. Chapman. Finally, Dr. Wahi also voluntarily dismissed Counts Seven and Eight. This now leaves the Court to address the following issues: a) whether CAMC is entitled to immunity under HCQIA from civil liability for all counts except the civil rights claims; and b) whether any genuine issue of material fact remains for Counts Three, Four, and Six.

II. THE HEALTH CARE QUALITY IMPROVEMENT ACT (HCQIA)

The HCQIA was enacted in 1986 to improve the quality of medical care by restricting the ability of physicians who have been found to be incompetent from repeating this malpractice by moving from state to state without discovery of such finding. *Imperial v. Suburban Hospital Ass'n, Inc.*, 37 F.3d 1026, 1028 (4th Cir.1994) (citing 42 U.S.C. § 11101). The HCQIA establishes a national reporting system to follow bad doctors from place to place, and provides immunity from damages for persons participating in professional review activities. *Imperial*, 37 F.3d at 1028.

To assure that hospitals and doctors cooperate with the system and engage in meaningful professional review, Congress found it necessary to provide qualified immunity from damages actions for hospitals, doctors, and others who participate in the professional review process. *Id.* (citing 42 U.S.C. § 11101). "Thus, 42 U.S.C. § 11101 provides that persons participating in professional review activities that meet the standards outlined in 42 U.S.C. § 11112, 'shall not be liable in damages under any law of the United States or any State' with respect to the person's participation in such activities."

Imperial, 37 F.3d at 1028. The conditions set forth granting such immunity are set forth in § 11112(a) and are discussed below.

A. Qualifications for HCQIA Immunity

The HCQIA provides immunity from damages for those who participate in professional peer review. For HCQIA immunity to attach, however, the peer review action must comport with due process. *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 211 (4th Cir.2002). To determine whether an action comports with due process, the HCQIA adopts a four pronged test. Specifically, the peer review action must be taken (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts. 42 U.S.C. § 11112(a)(1)-(4). The standard laid out by the test is one of objective reasonableness, looking at the totality of the circumstances. *Freilich*, 313 F.3d at 212 (quoting *Imperial v. Suburban Hospital Assoc.*, 37 F.3d 1026, 1030 (4th Cir.1994)).

In meeting this test, § 11112(a) of the HCQIA provides a presumption in favor of the health care entity. It is presumed that a health care entity has met the necessary standards and is entitled to immunity unless the presumption is rebutted by a preponderance of the evidence. § 11112(a). In order for an entity to continue to qualify for immunity, § 11133 requires that the outcomes of professional

review actions be reported to state boards of medical examiners. There is no immunity from claims alleging a civil rights violation or claims for declaratory or injunctive relief. *Imperial,* 37 F.3d at 1030 (citing 42 U.S.C. § 11112).

B. Determination of Whether This is a Peer Review Action

Dr. Wahi argues that the underlying suit does not arise as the result of a professional peer review action. Under the HCQIA only actions that meet the definition of professional review are eligible for immunity. *Gordon v. Lewistown Hospital,* 423 F.3d 184, 201 (3d Cir.2005). Therefore, this court will first address whether the action qualifies as a peer review action before applying the four § 11112(a) factors to determine immunity.

The HCQIA defines professional review action as:

> [A]n action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

§ 11151(9). Professional review activity "means an activity of a health care entity with respect to an individual physician-(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity, (B) to determine the scope or conditions of such privileges or membership, or (C) to change or modify such privileges or

membership." § 11151(10).

In the present action, it is clear that the suit arises as a result of the recommendations and activities of a health care entity in regard to the competence and professional conduct of Dr. Wahi, and whether he will continue to have privileges at CAMC. The decisions of CAMC have, in fact, adversely affected Dr. Wahi's privileges. Furthermore, the statute does not require that the activities or actions be properly conducted or conducted in a specific manner in order to be deemed a professional review action. Thus, regardless of whether this court determines CAMC's activities to be proper, the underlying action is subject to the requirements of the HCQIA. Having determined that the current action is a suit arising as the result of a peer review activity, the court will now determine whether the actions of CAMC are entitled to immunity under the HCQIA.

C. Summary Judgment and the HCQIA

As stated above, § 11112(a) provides a presumption that a health care entity has met the necessary standards laid out by the statute, and thus is entitled to immunity unless this presumption is rebutted by a preponderance of the evidence. This presumption of immunity established by the HCQIA creates a unique summary judgment standard. *See Gabaldoni v. Washington County Hospital,* 250 F.3d 255, 260 (4th Cir.2001) (finding that due to the presumption of immunity contained in § 1 1112(a), an unconventional standard must be applied in determining whether the hospital was entitled to summary judgment). When reviewing a motion for summary judgment under the HCQIA, the plaintiff

bears the burden of proving that a reasonable jury, examining all the facts in the light most favorable to the plaintiff, would find that the plaintiff has shown by a preponderance of the evidence that the professional review process failed the test for reasonableness as laid out in the HCQIA. *Gabaldoni*, 250 F.3d at 260.

D. Application of the Test Outlined in the HCQIA: 42 U.S.C. § 11112(a) Standards

In applying the test outlined in § 11112(a), we begin with the presumption that the hospital has met the necessary standards for immunity unless this presumption is rebutted by a preponderance of the evidence. § 11112(a). The applicable standard is one of objective reasonableness, viewed in light of the totality of the circumstances. *Freilich*, 313 F.3d at 212 (quoting *Imperial v. Suburban Hospital Assoc.*, 37 F.3d 1026, 1030 (4th Cir.1994)). Reasonableness standards have been consistently upheld in the context of qualified immunity. *Freilich*, 313 F.3d at 213. Such standards are often applied in this context to afford the officials, or in this the case the doctors and hospital involved, sufficient latitude to properly perform discretionary functions. *Id.* The Fourth Circuit in *Imperial* interpreted the language of the first prong of the test, that the action be taken in the *reasonable belief* that quality health care was being furthered, as establishing a standard of objective reasonableness looking to the totality of the circumstances. *Imperial*, 37 F.3d at 1030. The Fourth Circuit reaffirmed this interpretation in *Freilich*. The Fourth Circuit then elaborated in *Freilich* stating that the objective reasonableness standard is a valid guide for peer review bodies. "The 'reasonable belief' standard embodies the discretion that health care

professionals have traditionally exercised in determining whether or not their peers meet a requisite level of professional competence." *Freilich*, 313 F.3d at 212. The test consists of four-prongs and states that:

> [t]he peer review action must be taken (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts.

42 U.S.C. § 11112(a)(1)-(4). Each of these prongs will be discussed in turn.

1. Reasonable Belief That Action was in Furtherance of Quality Health Care

The first prong outlined in 42 U.S.C. § 11112(a)(1) requires that a peer review action be taken in the reasonable belief that it was in furtherance of quality health care. "This prong of the test is met if the reviewers, with the information available to them at the time of the professional review action would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." *Brader v. Allegheny General Hospital*, 167 F.3d 832, 840 (3d Cir.1999). The HCQIA does not require that professional review activities actually better health care, but only that review actions be undertaken in the reasonable belief that quality health care was being furthered.

Imperial v. Suburban Hospital, 37 F.3d 1026, 1030 (4th Cir.1994).

We begin with the presumption that the hospital has met this prong of the test. Dr. Wahi then has the burden of offering evidence sufficient to overcome this presumption. Dr. Wahi argues that the peer review action taken against him was not taken to further quality health care, but was an attempt by CAMC to unlawfully restrain competition in cardiac and thoracic surgery. As evidence, Dr. Wahi offers the outcomes of the investigations conducted against him. He points to the fact that in these investigations he was not found to have deviated from the standard of care.

He concludes that since he did not stray from the standard of care the actions could not have been taken in the reasonable belief of furthering quality health care, and that therefore the investigation was for anti-competitive reasons. This evidence does not rebut the presumption that the hospital acted reasonably, because it is not necessary that the actions actually improve health care or prove that Dr. Wahi provided substandard care, but instead that the hospital reasonably believe that some action is warranted. *Imperial*, 37 F.3d at 1030. As evidence of the hospital's anti-competitive motives, Dr. Wahi alleges that the investigation occurred after he met with staff from Bluefield Regional Hospital (Bluefield) and had a patient referred to him by that hospital. He states that CAMC only looked into his treatment of said patient, because he had been in touch with Bluefield about their interest in cardiac surgery. As support for this contention, Dr. Wahi cites his own deposition and his own affidavit. He offers nothing more than his personal belief that this

action had an anti-competitive motive. Self-serving opinions without objective corroboration are not considered to be probative, and thus this evidence is irrelevant. *Evans v. Technologies Applications & Service, Co.*, 80 F.3d 954, 962 (4th Cir.1996).

The evidence that CAMC's actions were taken in the reasonable belief of furthering quality health care is overwhelming. CAMC took action after numerous reports and complaints surfaced regarding Dr. Wahi's competence and inability to practice within the scope of his privileges. The hospital offers the depositions of several doctors stating that Dr. Wahi continued to act outside the scope of his restrictions, and that his actions posed a threat of danger to patients. Even a letter from St. Francis, relied on by Dr. Wahi, states that he was suspended because he failed to practice within the self imposed limits of his privileges. Plaintiff's Exhibit 18.

A reasonable jury could not find that Dr. Wahi has shown by a preponderance of the evidence that the hospital's action was not taken in the reasonable belief that it was in the furtherance of quality health care. In fact, Dr. Wahi has failed to offer even a scintilla of relevant evidence to show that the hospital acted unreasonably. Dr. Wahi has failed to rebut the presumption that the professional review action of CAMC was taken in the reasonable belief that it was in furtherance of quality health care.

2. Reasonable Effort to Obtain the Facts

The second prong in evaluating a claim for immunity is that the reviewing entity make a reasonable effort to obtain the facts. 42 U.S.C. § 11112(a)(2). This prong is met when "the totality of the process leading up to the Board's professional

review action ... evidenced a reasonable effort to obtain the facts of the matter." *Brader v. Allegheny General Hospital,* 167 F.3d 832, 841 (3d Cir.1999).

Again we begin with the presumption that CAMC has made a reasonable effort to obtain the facts of the matter. The plaintiff offers nothing to rebut this presumption.

We find that no reasonable jury could find that CAMC took action without a reasonable effort to obtain the facts of the matter. CAMC enlisted the assistance and recommendations of numerous physicians and committees in conducting several investigations and peer reviews of Dr. Wahi and his patient care. CAMC has satisfied the second prong of this test.

3. Adequate Notice and Hearing Procedures, or Other Such Procedures as are Fair Under the Circumstances

The third prong of 42 U.S.C. § 11112(a) requires that the peer review action be taken after adequate notice and hearing procedures are afforded to the physician involved, or after such other procedures as are fair to the physician under the circumstances are provided. 42 U.S.C. § 11112(a)(3). This prong can be satisfied in a number of ways. The HCQIA provides that one way to ensure this prong has been satisfied is for the hospital to fulfill the requirements of the HCQIA's safe harbor provision § 11112(b). We note, however, that failure to meet all the provisions outlined in § 11112(b) does not in itself constitute a failure to meet the adequate notice and hearing standards of subsection (a)(3). *Meyers v. Columbia/HCA Healthcare, Corp.*, 341 F.3d 461, 471 n. 6 (6th Cir.2003) (quoting language from

§ 11112(b)). The plain language of § 11112(a)(3) indicates that a hearing is not the only way to fulfill this prong. It can also be met by the provision of "such other procedures as are fair to the physician under the circumstances provided." § 11112(a)(3). This is in keeping with the test's overall standard of objective reasonableness in light of the totality of the circumstances.

We begin with the presumption that CAMC fulfilled the requirements of the third prong of this test. Dr. Wahi contends that CAMC failed to meet this prong, because it failed to comply with certain provisions of § 11112(b). In particular he alleges that CAMC did not set a hearing date, and did not provide him with a list of witnesses. We will first look at the evidence offered by Dr. Wahi to support his contention that he was not given adequate notice and hearing procedures or other such procedures fair to him under the circumstances. We will then look at the evidence provided by the hospital as to the procedures it provided. In order to rebut the presumption that the hospital met the third prong of this test, Dr. Wahi must show that a reasonable juror looking at the facts in the light most favorable to him, would find that he has shown by a preponderance of the evidence that the professional review process used by the hospital did not provide him adequate notice and hearing procedures or other procedures fair to him under the circumstances.

As evidence that CAMC failed to meet the third prong of the HCQIA immunity test, Dr. Wahi cites from the hospital's bylaws, and the HCQIA sections requiring the provision of a witness list and notice of the date of the hearing. He states in his brief to the court that this failure to follow procedures is

sufficient by itself to deny immunity to the defendants under the HCQIA. This is clearly contradicted by the plain language of the HCQIA. The Act states in § 11112(b) that "a professional body's failure to meet the conditions described in this subsection [11112(b)] shall *not,* in itself, constitute failure to meet the standards of subsection (a)(3) of this section." *Meyers,* 341 F.3d at 471 n. 6 (quoting § 11112(b)) (emphasis added).

We now look at the procedures that were provided by CAMC to Dr. Wahi. CAMC corresponded with Dr. Wahi on numerous occasions regarding the proposed actions, his right to request counsel, a summary of his rights at any subsequent hearing, as well as, an opportunity to appear and speak at any committee meetings where concerns were raised regarding Dr. Wahi's privileges. CAMC first sent Dr. Wahi a letter on July 8, 1999, informing him that the Credentials Committee was considering denying his request for reappointment to the medical staff. In accordance with the hospital's Medical Staff Procedures Manual, this letter offered Dr. Wahi the opportunity to meet with the Credentials Committee. The letter also told Dr. Wahi when the next meeting would take place and informed him of the nature of the allegations and evidence against him. Defendant's Exhibit 27. Throughout July, CAMC kept Dr. Wahi informed of the allegations and investigations being conducted in a series of letters and meetings with Dr. Wahi. Defendant's Exhibits 55, 29, 56, 57, 58, 60; and Plaintiff's Exhibit 8. Dr. Wahi acknowledges awareness of the allegations in a letter to the Dr. Crotty dated July 15, 1999. Defendant's Exhibit 55. In it he states:

I understand questions have arisen regarding my

> treatment of this patient and whether or not the procedure performed was authorized under the privilege [sic] I currently hold at CAMC. I am writing to provide you with additional information which I ask the reviewer to consider.

Letter from Dr. Wahi to Dr. Crotty (Defendant's Exhibit 55).

In August, CAMC informed Dr. Wahi of the specific issues that would be discussed at the meeting and again invited him to attend the meeting. This letter states in relevant part:

> You will be informed of the general nature of the evidence supporting the action contemplated by the Credentials Committee at your meeting with them on August 17, 1999. You will be invited to discuss, explain, or refute it. This meeting is your opportunity to present the Committee with additional information that is pertinent to its evaluation ...

Letter from Dr. Crotty to Dr. Wahi dated August 14, 1999. (Defendant's Exhibit 64). Dr. Wahi does not dispute receiving any of the above mentioned correspondence.

Dr. Wahi's attorney, after receiving the above described correspondence, sent a letter to CAMC dated September 8, 1999, on Dr. Wahi's behalf, requesting a hearing pursuant to CAMC's Medical Staff Procedures Manual. Defendant's Exhibit 38. After a series of discussions between Dr. Wahi's attorney and CAMC, CAMC sent a letter dated December 2, 1999, with details about the hearing and stating the hearing would be held at a date convenient to all parties. Defendant's Exhibit 41. By late December CAMC was still waiting to hear of a

date that was amenable to Dr. Wahi and his counsel. On December 21, 1999, Cheryl A. Eifert, the Hearing Officer appointed by CAMC, sent a letter to Dr. Wahi's counsel stating, "I am also waiting to hear from you for the scheduling of the hearing requested by Dr. Wahi." Defendant's Exhibit 67.

In July of 2000, the hospital had a telephone conference with Dr. Wahi's counsel to resolve the matters in controversy between them, including Dr. Wahi's pending hearing request. Dr. Wahi's counsel at the time, George Guthrie, sent a letter to Cheryl Eifert attaching a proposal whose purpose was to resolve the matters without any litigation, administrative or otherwise. Defendant's Exhibit 68. These negotiations apparently fell through and in the fall of 2000, the two parties remained embroiled in discussions about the parameters and dates of a hearing. The hospital informed Dr. Wahi that it would not change the hearing procedures from those stated in the manual and that a hearing would be scheduled. In a letter dated October 11, 2000, Cheryl Eifert again requests that Dr. Wahi provide her with dates for the hearing. She writes in relevant part:

> I do request that you provide me with dates for the administrative hearing at your earliest convenience. I anticipate the hearing will take a number of days; therefore, I suggest that we select dates well enough in advance that all involved parties can clear their schedules.

Defendant's Exhibit 72.

In November of 2000, Dr. Wahi filed suit in Kanawha County Circuit Court to enjoin the proceedings. The Kanawha County Court refused to rule on the fairness of the hearing until after a

hearing was held. No hearing has been conducted and this lawsuit has proceeded from that point.

Even though a hearing was not held, this court finds that the evidence offered by Dr. Wahi is insufficient for a reasonable jury to find that CAMC failed to fulfill its obligations under § 11112(a)(3) by a preponderance of the evidence. The overwhelming evidence is that CAMC acted in an objectively reasonable manner in light of the totality of the circumstances in this case and took sufficient measures to ensure Dr. Wahi received adequate notice of any hearing or meeting that was to occur in the proposed actions against him. The many letters between the parties illustrate the hospital's attempts to set a hearing at Dr. Wahi's request and give him notice of the hearing. Dr. Wahi was represented by counsel throughout the entire process and in the end, he was informed and fully aware of his rights, the hospital's policies, and the charges and evidence the hospital had against him. The hospital responded promptly when Dr. Wahi requested a hearing be scheduled.

The court finds that in light of the evidence presented by Dr. Wahi and by CAMC a reasonable jury could not conclude that Dr. Wahi has shown by a preponderance of the evidence that CAMC failed to provide him adequate process as required by § 11112(a)(3). CAMC has fulfilled the third prong of the HCQIA test.

4. Reasonable Belief that the Action was Warranted

The fourth prong to establish immunity, 42 U.S.C. § 11112(a)(4), requires that the reviewers have a reasonable belief that the action is warranted. In

determining whether an action was warranted, the analysis is very similar to the analysis under § 11112(a)(1), thus the court does not repeat the arguments and analysis already addressed under 42 U.S.C. § 11112(a)(1). *Gabaldoni v. Washington County Hospital,* 250 F.3d 255, 263 n. 7 (4th Cir.2001).

Dr. Wahi argues that because some of the committees who reviewed his work and treatment of specific patients felt that he followed the necessary standard of care that his privileges should not have been suspended. For the action to be warranted, it is not necessary that every committee that reviews a physician come to the same conclusion. *Brader,* 167 F.3d at 843. Dr. Wahi has not put forth sufficient evidence to overcome the presumption that the hospital had a reasonable belief that its action was warranted. The hospital has satisfied the fourth prong of this test.

C. Findings

In light of the above analysis, this Court finds that defendant is entitled to immunity under 42 U.S.C. § 11111(a). The plaintiff has failed to offer sufficient evidence upon which a reasonable jury, examining all the facts in the light most favorable to him, could find by a preponderance of the evidence that the professional review process failed the test for reasonableness as laid out in § 11112(a) of the HCQIA. As such defendants are entitled to immunity from damages for Counts I, II, III, and V.

III. SUMMARY JUDGMENT ON THE REMAINING ISSUES

To obtain summary judgment, the moving party must show that there is no genuine issue as to any

material fact and that the moving party is entitled to judgments as a matter of law. Fed.R.Civ.P. 56(c). In considering a motion for summary judgment, the court will not "weigh the evidence and determine the truth of the matter." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). Instead, the court will draw any permissible inference from the underlying facts in the light most favorable to the nonmoving party. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587-88, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986).

Although the court will view all underlying facts and inferences in the light most favorable to the nonmoving party, the nonmoving party nonetheless must offer some "concrete evidence from which a reasonable juror could return a verdict in his [or her] favor." *Anderson*, 477 U.S. at 256, 106 S.Ct. 2505. Summary judgment is appropriate when the nonmoving party has the burden of proof on an essential element of his or her case and does not make, after adequate time for discovery, a showing sufficient to establish that element. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). The nonmoving party must satisfy this burden of proof by offering more than a mere "scintilla of evidence" in support of his or her position. *Anderson*, 477 U.S. at 252, 106 S.Ct. 2505.

A. Breach of Contract Claims

Dr. Wahi asserts two breach of contract claims in his complaint, one alleging a breach of contract due to CAMC's violation of its Medical Staff Procedures Manual, and the other alleging a civil rights violation under 42 U.S.C. § 1981. The definition of the term contract is more narrow for the former claim than for

the latter. The court finds, for the reasons discussed below, that there was no contract between CAMC and Dr. Wahi for the purposes of the state law claim, and that a contract did exist for the purposes of his § 1981 claim. Each of these claims is discussed in full below.

1. State Law Breach of Contract Claim

Dr. Wahi claims that CAMC is contractually bound by the Medical Staff Procedures Manual as part of its agreement with him. Dr. Wahi contends that CAMC breached its contract with him by failing to provide a hearing on his summary suspensions "as soon as practicable" and by failing to provide a fair hearing. Under West Virginia law, unless there is express language to the contrary, medical staff bylaws do not constitute a contract between hospital and physician. *Kessel v. Monongalia County General Hospital*, 215 W.Va. 609, 600 S.E.2d 321, 324 Syl. Pt. 4 (2004). In *Kessel*, the West Virginia Supreme Court found that because hospitals are required by law to enact medical staff bylaws, the necessary consideration to form a contract is lacking, thus hospital bylaws cannot be considered a contract between the hospital and the physician. *Kessel*, 600 S.E.2d at 324. In the case at hand, the bylaws contained in CAMC's Medical Staff Procedures Manual do not include express language creating a contract as required by the West Virginia Supreme Court. Dr. Wahi's claim fails because the bylaws do not constitute a contract under West Virginia law.

The physician does possess due process rights. Where it is alleged that a physician is guilty of professional incompetence or misconduct, the hospital is bound by the fair hearing procedural provisions contained in the medical staff bylaws, but this does

not transform the bylaws into a contract. *Id.* at 326-27. The Supreme Court of West Virginia is concerned with whether a physician is given basic procedural due process protections. As long as a hospital's bylaws provide basic procedural protections, and these bylaws are substantially followed in a particular disciplinary proceeding, a court will usually not interfere with the committee's recommendation. *Mahmoodian v. United Hospital Center,* 185 W.Va. 59, 404 S.E.2d 750, 755-56 (1991). Finally, *Kessel* also recognizes that federal legislation has been enacted to encourage all hospitals to use the same professional review procedures. *Kessel,* 600 S.E.2d at 330.

As discussed in section II.D.3, CAMC provided Dr. Wahi with notice of upcoming committee meetings, the nature of the charges against him, and outlined the rights and remedies available to him. There is no genuine issue of material fact as to whether CAMC substantially complied with the procedures outlined in its manual and with the federal standards outlined in the HCQIA. Therefore, summary judgment is **GRANTED** in favor of the defendant on the plaintiff's breach of contract claim.

2. 42 U.S.C. § 1981

a) Existence of a Contract

The court must now determine whether a contract exists between Dr. Wahi and CAMC for the purposes of § 1981. The bylaws, as discussed above, do not constitute a contract under West Virginia law between a hospital and a physician. Dr. Wahi does not allege any contractual rights based on his status as an at-will employee. Under § 1981, Dr. Wahi does, however, have some basic contractual rights based on

his position as an at-will employee. In *Spriggs,* the Fourth Circuit held that an at-will employment relationship is contractual and can serve as the predicate contract for a § 1981 claim. *Hawkins v. PepsiCo, Inc.,* 203 F.3d 274, 278 (4th Cir.2000) (citing *Spriggs v. Diamond Auto Glass,* 165 F.3d 1015, 1018-19 (4th Cir.1999)). The definition of a contract under § 1981 simply requires that there be an offer of employment, an acceptance of that offer, and consideration in the form of labor. *Spriggs,* 165 F.3d at 1018. Dr. Wahi applied to be re-credentialed at CAMC, CAMC then offered to extend privileges to Dr. Wahi, and Dr. Wahi accepted the offer and began performing services at CAMC in exchange for pay.

b) Statute of Limitations

There are two issues to address in assessing Dr. Wahi's § 1981 breach of contract claim. The first is whether the statute of limitations has run on his claim, and if it has not whether his claim survives summary judgment. Section 1981 does not contain a statute of limitations. When this is the case, a court must determine whether the relevant section of the statute was enacted before or after December 1, 1990. If enacted before December 1, 1990, the statute of limitations should generally be determined by adhering to the most analogous state statute of limitations. For laws enacted after December 1, 1990, and not containing a statute of limitations, Congress enacted a four year catchall statute of limitations in 28 U.S.C. § 1658. *Jones v. R.R. Donnelley & Sons,* 541 U.S. 369, 371, 124 S.Ct. 1836, 158 L.Ed.2d 645 (2004).

The statute at issue here is 42 U.S.C. § 1981, first enacted in 1866. Thus it would first appear that we

should apply the most analogous state statute of limitations. For claims arising under § 1981, however, the analysis does not end here, because Congress passed a major amendment to the statute which went into effect on November 21, 1991. Civil Rights Act of 1991, Pub.L. No. 102-166, § 101, 105 Stat. 1071 (1991). In this amendment, Congress defined the term "to make and enforce contracts." This amendment added subsections (b) and (c) to § 1981. These new subsections state:

(b) For the purposes of this section, the term 'make and enforce contracts' includes the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship. (c) the rights protected by this section are protected against impairment by nongovernmental discrimination and impairment under color of state law.

Id.

When determining the statute of limitations for a cause of action under § 1981, a court must decide whether the suit arises under the 1991 amendment or under the statute as originally enacted. If the plaintiff's claim was made possible because of the post-1990 enactment, it is governed by § 1658's four year statute of limitations. *Jones*, 541 U.S. at 382, 124 S.Ct. 1836.

In the present case, Dr. Wahi's cause of action under § 1981 was made possible by the 1991 amendment and thus is subject to the four year statute of limitations. Prior to 1991, Dr. Wahi would not have been able to bring a cause of action for the alleged harassing and discriminatory conduct that he

faced after the formation of his contract with CAMC. *See Jones,* 541 U.S. at 383, 124 S.Ct. 1836 (finding that a claims for hostile work environment were only possible under the post-1990 amendment to § 1981 and therefore the four year statute of limitations applied).

In determining when the statute of limitations begins to accrue on a § 1981 action, the "proper focus is on the time of the discriminatory act, not the point at which the consequences of the act become painful." *Chardon v. Fernandez,* 454 U.S. 6, 8, 102 S.Ct. 28, 70 L.Ed.2d 6 (1981). Section 1981 claims for wrongful termination accrue on the date the employer notifies the employee that he is being terminated. *Nghiem v. U.S. Department of Veteran Affairs,* 451 F.Supp.2d 599, 604-05, 2006 WL 2572658 *4 (S.D.N.Y. 2006). *See also Chardon v. Fernandez,* 454 U.S. 6, 8, 102 S.Ct. 28, 70 L.Ed.2d 6 (1981) (stating that the relevant date is when the employee is denied tenure).

In the present case, Dr. Wahi was notified by letter on July 30, 1999, that his medical staff privileges at CAMC were being summarily suspended. Defendants Exhibit 32. This suspension is the alleged discriminatory act at issue in this case. Dr. Wahi alleges three later dates on which the statute of limitations could have started to run. There were no subsequent actions taken after July 30, 1999, that further affected Dr. Wahi's ability to enjoy his contractual rights under § 1981, including the rights to "enjoyment of all benefits, privileges, terms, and conditions of [his] contractual relationship." § 1981(b). Thus, this court is convinced that the relevant date for determining when the statute of limitations began to run is July 30, 1999. Therefore, the statute of limitations has run on Dr. Wahi's

§ 1981 claim, and his claim is barred.

c) 42 U.S.C. § 1981 Analysis

For purposes of this brief analysis it will be taken as true that Dr. Wahi has an employment contract with CAMC and that the statute of limitations has not run on Dr. Wahi's cause of action. Section 1981 grants all persons within the jurisdiction of the United States "the same right ... to make and enforce contracts ... as is enjoyed by white citizens." 42 U.S.C. § 1981(a). In order to survive a motion for summary judgment, a plaintiff under § 1981 may proceed through two avenues of proof. He can either illustrate direct evidence of discrimination or he can proceed under the burden shifting framework set forth in *McDonnell Douglas Corp. v. Green,* 411 U.S. 792, 93 S.Ct. 1817, 36 L.Ed.2d 668 (1973). Since Dr. Wahi does not present any direct evidence of intentional discrimination on the part of CAMC, he must proffer sufficient circumstantial evidence to satisfy the *McDonnell Douglas* analytical framework. *Williams v. Staples, Inc.,* 372 F.3d 662, 667 (4th Cir.2004). Under this framework, the plaintiff must first establish a *prima facie* case of discrimination, the defendant may respond with a legitimate, nondiscriminatory reason, and then the plaintiff may adduce evidence to show that the defendant's proffered reason was mere pretext and that race was the real reason for disparate treatment. *Id.* (citing *Hawkins v. PepsiCo, Inc.,* 203 F.3d 274, 278 (4th Cir.2000)). In assessing whether the plaintiff has provided sufficient evidence such that his case may proceed to trial, this court's decision is informed by the summary judgment standard. *Hux v. Newport News,* 451 F.3d 311, 315 (4th Cir.2006).

The first prong of the framework is for the plaintiff to establish a *prima facie* case of discrimination. The test for proving *prima facie* disparate disciplinary practices consists of the following three elements: (1) the plaintiff is a member of a protected class; (2) the prohibited conduct in which the plaintiff engaged was as serious as the misconduct of employees outside the protected class; and (3) the employer imposed harsher disciplinary measures against plaintiff than against employees outside the protected class. *Carter v. Ball,* 33 F.3d 450, 460 (4th Cir.1994) (citing *Cook v. CSX Transp. Corp.*, 988 F.2d 507, 511 (4th Cir.1993)).

Dr. Wahi is a member of a protected class. He alleges in his affidavit that Caucasian doctors have engaged in more serious misconduct, but have had no disciplinary measures taken against them. Assuming *arguendo* that Dr. Wahi has made out a *prima facie* case of race discrimination the burden now shifts to CAMC to articulate some legitimate non-discriminatory reason for its action. *O'Connor v. Consolidated Coin Caterers Corp.*, 517 U.S. 308, 311, 116 S.Ct. 1307, 134 L.Ed.2d 433 (1996) (internal quotation marks omitted). Once CAMC meets this burden, Dr. Wahi must prove that CAMC's proffered reason was mere pretext and that race was the real reason for the discrimination. *Hawkins v. PepsiCo, Inc.*, 203 F.3d 274, 278 (4th Cir.2000).

CAMC states that it disciplined Dr. Wahi out of concern for the health and safety of his patients. CAMC offers evidence that Dr. Wahi was disciplined because his practices were not safe and exposed patients to unacceptable risk. Although Dr. Wahi disputes accepting the findings of the Third Review Committee, he voluntarily relinquished his privileges

in 1995. After additional training, Dr. Wahi was allowed to return to practice at CAMC with severe restrictions on his privileges, and when those restrictions were violated, CAMC took action. In light of these uncontroverted facts, CAMC has met its burden by providing evidence that it acted out of these health and safety concerns and not because Dr. Wahi is Indian.

Dr. Wahi now has the burden of showing that the hospital's legitimate, nondiscriminatory justifications for its actions were pretextual. The limited evidence that Dr. Wahi offers to support his contentions that CAMC's reasons were pretextual consists of his self-serving affidavit. In his affidavit he makes accusations against various colleagues pointing to instances where he believes they provided substandard health care resulting in the deaths of multiple patients. He then notes that none of these colleagues were disciplined, and concludes that this was due to race. Dr. Wahi also alleges racial discrimination on the part of the committee, because some of its members were of Pakistani descent, and he believes that they discriminated against him because he is Indian and Hindu. These allegations are not supported by objective evidence. A plaintiff cannot establish pretext by relying on criteria of his own choosing when the employer based its decision on other grounds. *Hux*, 451 F.3d at 315 (quoting *Anderson v. Westinghouse Savannah River Co.*, 406 F.3d 248, 271 (4th Cir.2005)). Self-serving opinions, without corroborating objective evidence, are not considered to be significantly probative. *See Evans v. Technologies Applications & Service Co.*, 80 F.3d 954, 962 (4th Cir.1996) (finding district court's decision to strike portions of plaintiff's affidavit not improper as

the portions struck contained self-serving opinions and unsupported assertions of colleagues' qualifications). Generally, an affidavit filed in opposition to a motion for summary judgment must present evidence in substantially the same form as if the affiant were testifying in court. *Id.* Summary judgment affidavits cannot be conclusory or based on hearsay. *Id.* Additionally, Dr. Wahi's affidavit does not offer any evidence that these were similarly situated physicians. Dr. Wahi already had restrictions placed on his practice. He does not contend that these other physicians were operating under similar restrictions.

Plaintiff's attempt to find pretext in the hospital's neutral explanation consists of comparing himself to various physicians based on his personal observations. He cannot simply compare himself to other physicians based on his personal evaluation of their care. His evaluations of other physicians' practices are irrelevant to the validity of CAMC's explanation for its actions. *See Hux*, 451 F.3d at 315 (noting that a plaintiff cannot establish pretext by relying on criteria of her choosing when the employer based its decision on other grounds) (quoting *Anderson*, 406 F.3d at 271). The evidence presented by Dr. Wahi fails to cast doubt on the validity of CAMC's explanation, and therefore does not create a genuine dispute. Dr. Wahi's response to CAMC's neutral explanation for it's action is not sufficient to overcome the summary judgment standard. Therefore even if the statute of limitations has not run, the court would grant CAMC's motion for summary judgment on the § 1981 claim.

B. 42 U.S.C. § 1983

Dr. Wahi alleges that CAMC and the Board of Medicine conspired to deny him his medical license. "To establish a civil conspiracy under section 1983, Appellants must present evidence that the Appellees acted jointly in concert and that some overt act was done in furtherance of the conspiracy which resulted in Appellants' deprivation of a constitutional right." *Hinkle v. City of Clarksburg*, 81 F.3d 416, 421 (4th Cir.1996). "Appellants have a weighty burden to establish a civil rights conspiracy. While they need not produce direct evidence of a meeting of the minds, Appellants must come forward with specific circumstantial evidence that each member of the alleged conspiracy shared the same conspiratorial objective." *Id.* In order to survive a properly supported summary judgment motion, plaintiff's evidence must, at least, reasonably lead to the inference that defendants positively or tacitly came to a mutual understanding to try to accomplish a common and unlawful plan. *Id.*

In the case at hand, Dr. Wahi does not offer even a scintilla of evidence that there was communication between CAMC and the Board of Medicine beyond that required by law. Each letter or meeting that he identifies is one required by the state and federal reporting laws. The HCQIA requires that any time a health care entity takes a professional review action that adversely affects the clinical privileges of a physician for a period of longer than thirty days it must report this action to the Board of Medicine. *Fobbs*, 789 F.Supp. at 1063 (quoting language from 42 U.S.C. § 11133(a)(1)).

To support his contention, Dr. Wahi states that

CAMC reported him to the Board of Medicine and the Data Bank on various occasions leading the Board of Medicine to investigate him. He notes that he was investigated three times and on all three occasions the charges were dismissed due to lack of evidence. Dr. Wahi has offered no evidence that defendants and the Board of Medicine were not meeting simply to fulfill their obligations and rights under the HCQIA 11133(a)(1) and West Virginia Code § 30-3-14(b) reporting requirements. He has offered no evidence on this issue from which a reasonable juror could return a verdict in his favor. Therefore, the court **GRANTS** CAMC's motion for summary judgment on Dr. Wahi's § 1983 claim.

IV. REQUESTS FOR INJUNCTIVE RELIEF

The HCQIA does not provide immunity from injunctive relief. *Imperial,* 37 F.3d at 1030. However, because Dr. Wahi fails to make any argument or allege any facts that would entitle him to injunctive relief this court **GRANTS** defendants' Motions for Summary Judgment on Count I, Count II, and Count V.

The court **DIRECTS** the Clerk to send a copy of this Order to counsel of record and any unrepresented party.

ENTER: September 29, 2006

/s/ Joseph R. Goodwin
Joseph R. Goodwin
United States District Judge

APPENDIX D

IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHARLESTON DIVISION

CIVIL ACTION NO. 2:04-cv-00019

RAKESH WAHI, M.D.

Plaintiff,

v.

CHARLESTON AREA MEDICAL CENTER, et al.,

Defendants.

JUDGMENT ORDER

In accordance with the accompanying Order, the court orders that judgment be entered in favor of the defendants and that this case be dismissed and stricken from the docket of this court.

The court **DIRECTS** the Clerk to send a certified copy of this Judgment Order to counsel of record and any unrepresented parties.

ENTER: September 29, 2006

/s/ Joseph R. Goodwin
Joseph R. Goodwin
United States District Judge

APPENDIX E

UNITED STATES CODE

TITLE 42--THE PUBLIC HEALTH AND WELFARE

CHAPTER 117: ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

SUBCHAPTER I. PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

42 U.S.C. § 11112. Standards for professional review actions

(a) In general

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken--

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating—

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating--

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B)--

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)--

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right--

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right--

(i) to receive the written recommendation of the

arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

(c) Adequate procedures in investigations or health emergencies

For purposes of section 11111(a) of this title, nothing in this section shall be construed as--

(1) requiring the procedures referred to in subsection (a)(3) of this section--

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

(Pub. L. 99-660, title IV, §412, Nov. 14, 1986, 100 Stat. 3785.)

APPENDIX F

RECORD NO. 06-2162

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

RAKESH WAHI,

Plaintiff-Appellant,

v.

CHARLESTON AREA MEDICAL CENTER, INCORPORATED, a West Virginia Corporation; Glenn Crotty; John Does I-X,

Defendants-Appellees,

JANE DOES NUMBERS 1 THROUGH 10; JAMAL KAHN; H. RASHID; K.C. LEE; ANDREW VAUGHN; JOHN L. CHAPMAN,

Defendants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA AT CHARLESTON

BRIEF OF APPELLEES – UNDER SEAL

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(JA 786-88).

Id.[13]

Wahi failed to carry his burden before the district court to demonstrate by a preponderance of the evidence that CAMA did not afford him adequate notice and hearing procedures as were fair under the circumstances. The district court properly found that CAMC is entitled to HCQIA immunity and dismissed all claims within the scope of that immunity.

2. CAMA did not violate Wahi's due process rights or HCQIA by suspending him without a prior finding that he posed an imminent danger to patients.

Wahi alleges that CAMC deviated from its procedures manual when it summarily suspended him. He argues that a finding of "imminent danger" is necessary for his suspension, and that his suspension improperly lasted longer than fourteen (14) days. These arguments lack merit.

---

[13] Despite Defendants' repeated requests to jointly seek with Wahi a limited release of records from the Grant County action to use in this case, he refuses to join with Defendants. Although CAMC believes the district court had more than sufficient evidence for it to decide all material issues, an examination of the entirely of the record from the Grant County action would demonstrate that Wahi is not being candid. Certainly, Wahi knows that he had complete access to all records, obtained all records which he and his counsel sought, and knows full well the scope of the overwhelming evidence against him.

(4)

No. 09-430

Supreme Court, U.S.
FILED
DEC 14 2009
OFFICE OF THE CLERK

In The
Supreme Court of the United States

RAKESH WAHI,

Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *et al.*,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

REDACTED
BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

1. Whether Petitioner has presented compelling reasons to grant the Petition.

PARTIES TO PROCEEDING AND RULE 29.6 STATEMENT

Petitioner, Rakesh Wahi, was the plaintiff-appellant in the court below.

Respondents, Charleston Area Medical Center, Inc. ("CAMC"), and Glenn Crotty ("Crotty") were defendants/appellees below.

Pursuant to Supreme Court Rule 29.6, Respondent CAMC makes the following disclosures:

CAMC is a West Virginia nonstock, nonprofit corporation. As a nonstock corporation, CAMC has no owner. However, it is a subsidiary of CAMC Health System, Inc. ("CAMCHS") by virtue of its Articles of Incorporation and Bylaws naming CAMCHS as its sole Voting Member.

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INTRODUCTION

Petitioner, Wahi, seeks review of the Fourth Circuit's unanimous decision affirming the district court's award of summary judgment to the Respondents on the question of HCQIA immunity. However, Wahi presents no "compelling reasons" for his Petition for Writ of *Certiorari* ("Petition") to be granted. *See* Sup. Ct. R. 10. In an attempt to establish compelling reasons, Wahi contends that the Fourth Circuit's April 10, 2009, Opinion ("Opinion") creates conflicts between the circuits. Wahi's arguments are flawed, and the claimed conflicts do not exist.

First, Wahi contends that the Opinion, by affirming summary judgment without "the statutorily required possibility of imminent danger," is in conflict with decisions in four other circuits. (Pet. at 1). Wahi mischaracterizes the Opinion and the cited decisions. The Opinion does not challenge the holdings of other circuits that a possibility of "imminent danger" must be present before a professional review action can enjoy immunity under § 11112(c)(2). Rather, the Opinion holds that the requirements of subsection (c)(2) need not be satisfied here because the Respondents are entitled to immunity for having complied with the reasonableness requirements of 11112(a). *Wahi v. CAMC*, 562 F.3d 599, 608 (4th Cir. 2009). Additionally, the circuit decisions cited by Wahi do not hold, as Wahi advances, that every summary suspension must be analyzed under the "imminent danger" standard of § 11112(c) as opposed to the reasonableness standards of § 11112(a), as was done

here. Thus, the Opinion creates no conflict by finding immunity under subsection (a), or by declining to apply subsection (c)(2).

Next, Wahi argues that the Opinion "deepens a pre-existing and acknowledged split involving an [sic] HCQIA plaintiff's access to a jury." (Pet. at 26). This simply is not so. The only "split" that arguably exists between the circuits regarding the "availability of jury trials" relates to who acts as the fact-finder *at trial* on the issue of immunity, judge or jury, if material disputed facts exist which preclude summary judgment.[1] Given its holding that summary judgment was correctly granted, the Opinion did not reach this issue.

Wahi's claim that the Opinion "effectively denies all HCQIA plaintiffs a jury trial" on the issue of immunity, is discredited by a simple reading of the Opinion. (Pet. at 26). The Fourth Circuit applied the same well-settled test that has been uniformly employed by the other circuits when considering whether summary judgment is warranted on the question of HCQIA immunity under § 11112(a). In applying that test, the Fourth Circuit determined that Wahi failed to present sufficient evidence to allow a reasonable jury to find that the Respondents did not provide him with fair procedures under the circumstances. The Opinion does not hold, or even suggest, that a jury trial on the issue of immunity would never be available.

---

[1] *See Bryan v. James E. Holmes Regional Med. Ctr.*, 33 F.3d 1318, 1332-1333 (1194) and *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 33-35 (2002)

Finally, Wahi argues that this case "would be suitable for summary reversal" because "respondent [sic] concedes that it suspended Petitioner 'without a prior finding that he posed an imminent danger.'" (Pet. at 2). The Respondents make no such concession. Rather, Respondents argue, having demonstrated entitlement to immunity under § 11112(a), they need not even allege satisfaction of the "imminent danger" element of § 11112(c)(2). *Wahi*, 562 F.3d at 608. However, as the facts conclusively demonstrate that failing to suspend Wahi's medical staff privileges may have resulted in an "imminent danger" to patients, the Respondents submit that they are also entitled to summary judgment on the question of immunity under a proper § 11112(c)(2) analysis.

Wahi has failed to demonstrate compelling reasons to grant the Petition. The circuits have harmoniously applied the same legal test to the consideration of whether a defendant is entitled to HCQIA immunity as a matter of law for having complied with the reasonableness requirements of § 11112(a). That well-settled test was employed by the Fourth Circuit here. Wahi's Petition offers only a strained argument that the Fourth Circuit misapplied this test. Therefore, the Petition should be denied.

STATEMENT OF THE CASE

Statement of Facts

Wahi is far from the "excellent" physician portrayed in the Petition. Wahi first obtained privileges from CAMC in 1993. By early 1995, [redacted].[2] Upon investigation, Wahi's practices [redacted]. (JA 497-506), BIO 1a-14a. Those early findings led to ***Wahi's decision to*** [redacted]. (JA 509-510).

After [redacted], Wahi reapplied for privileges. (JA 511-515). On February 6, 1997, CAMC, while under no obligation to provide Wahi any privileges, granted him temporary, limited privileges [redacted]

---

[2] The original sources of the complaints against Wahi were not hospital administrators, members of the Medical Staff administration, or competing cardiovascular surgeons. Rather, they were the [redacted]. (JA 497-506).

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. (JA 516-33).

. (JA 517). At that time,

(JA 518, 519-22).

. (JA 527-31).

On February 26, 1999,

. (JA 532-71).

. At a meeting on July 6, 1999,

. (JA 572-73).

On July 13, 1999,

. (JA 574).

. (JA 578-81).

. (JA 582-85).[3]

(JA 611).

[3] A device inserted to "catch" clots and prevent them from being pumped into the lungs (pulmonary emboli). It is inserted through the jugular vein and is then deployed much like an umbrella opens

(JA 584)

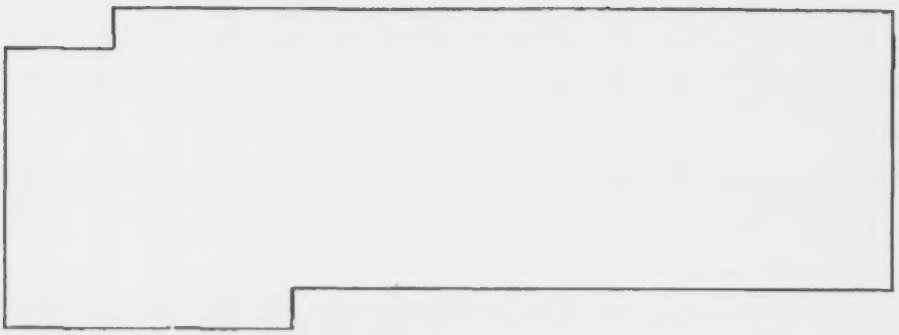
(JA 608).

. (JA 612-13).

.

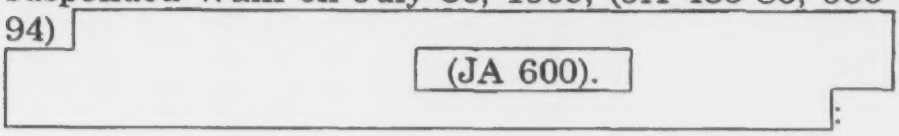
(JA 630).

(JA 632-33).

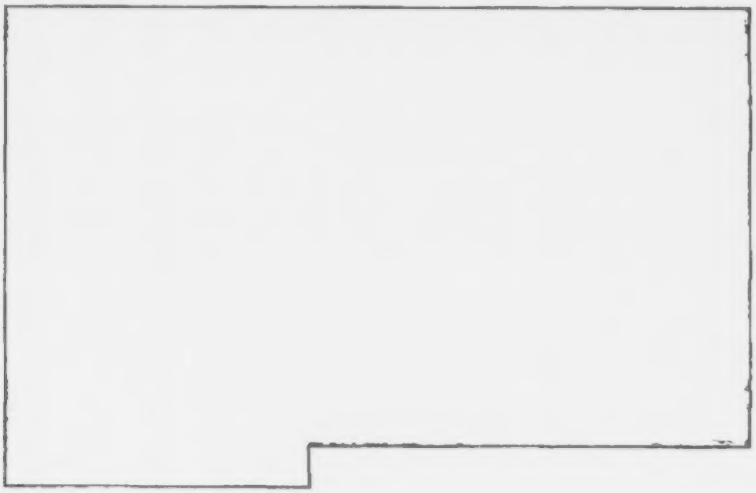


(JA 639) (emphasis added).

With this background, [redacted] summarily suspended Wahi on July 30, 1999, (JA 485-86, 586-94)

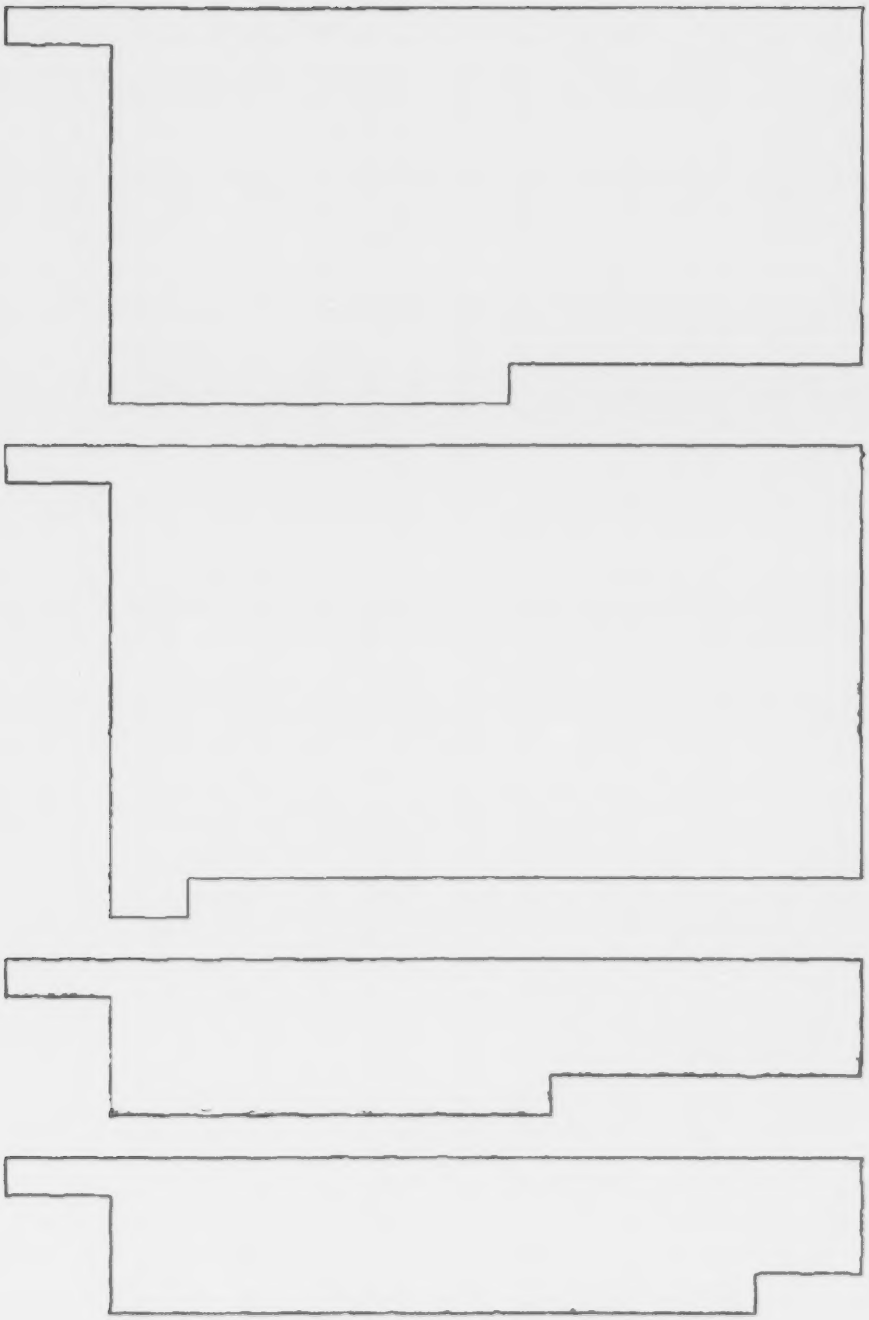


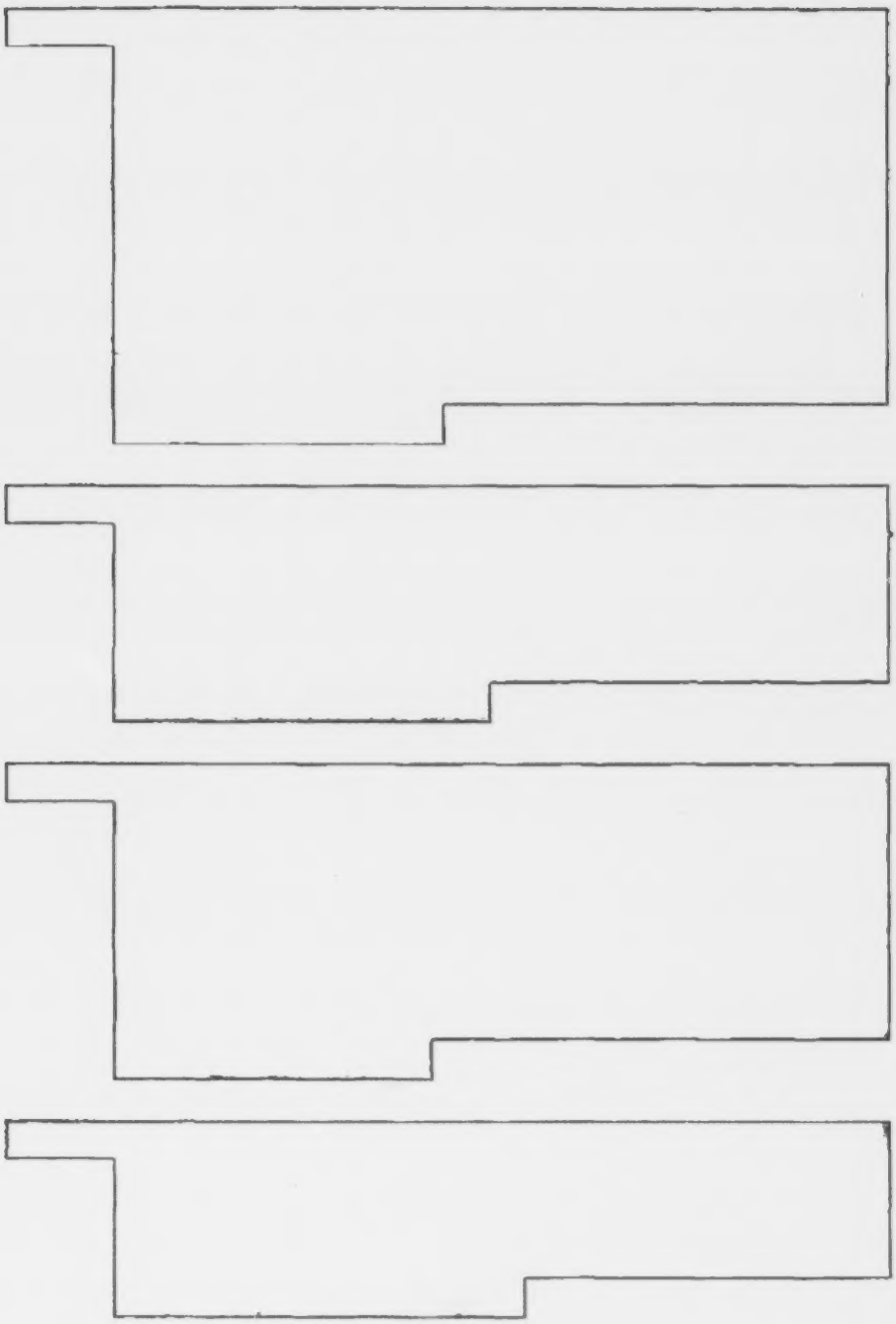
(JA 600).

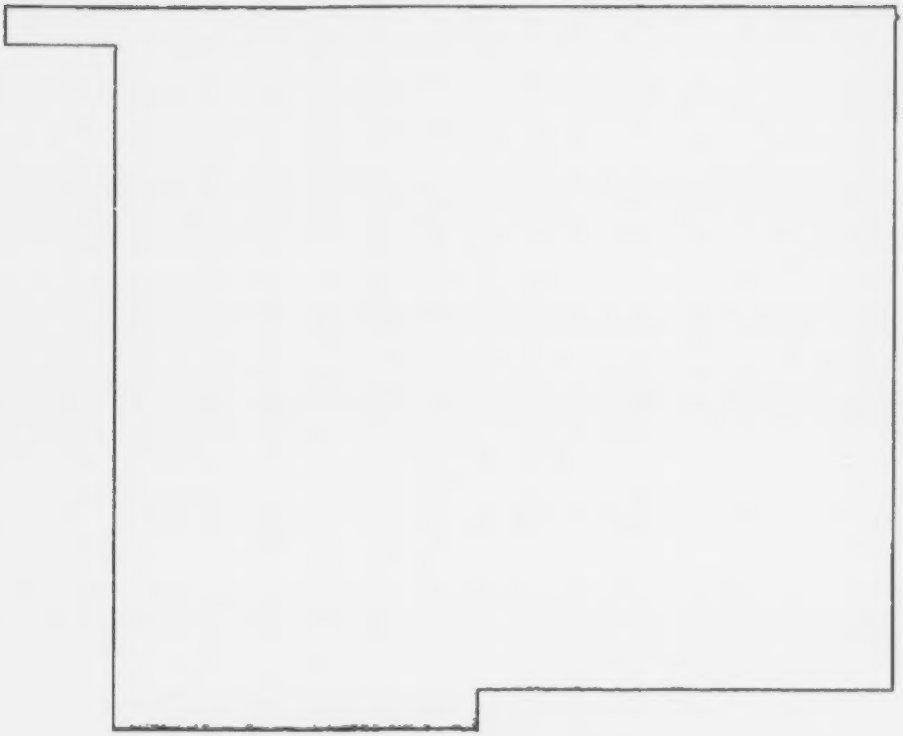


(JA 604-5).

The following events occurred in the weeks leading up to Wahi's suspension:







Brief Statement of Procedure

In the district court, Wahi asserted multiple claims, all of which were correctly addressed by the district court's order granting summary judgment. On appeal, Wahi abandoned many of his claims and focused largely on the question of HCQIA immunity. With respect to immunity, he relied primarily on the argument that summary judgment was not appropriate because no hearing had been held following his suspension.[4]

In addressing the district court's award of summary judgment on HCQIA immunity pursuant

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[4] A detailed procedural history of the case is laid out accurately in the Opinion.

to 11112(a), the Fourth Circuit noted that Wahi failed to raise any argument to support his claim that the first, second, and fourth prongs of subsection (a) were not met by the Respondents and concluded that Wahi "waived his claims" as to these subsections of the § 11112(a) HCQIA immunity test. Accordingly, the Fourth Circuit's review regarding immunity was limited to whether "the district court erred in determining that Wahi did not overcome the presumption that CAMC satisfied the requirements of subsection (a)(3)." *Wahi*, 562 F.3d at 607.

REASONS FOR DENYING PETITION

Brief Statement of Applicable Law

Congress enacted the Health Care Quality Improvement Act "to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior." H.R.Rep. No. 903, 99th Cong., 2d Sess. 2 (1986) *reprinted in* 1986 U.S.C.C.A.N. 6287, 6384. Congressional findings, recited in the statute, provide that "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State," and that these problems "can be remedied through effective professional peer review." 42 U.S.C. § 11101(1), (3) (2009). To further this goal, HCQIA provides immunity from money damages in suits brought by disciplined physicians against peer review participants. 42 U.S.C. § 11111(a) (2009). The immunity is designed to facilitate frank peer

review by eliminating the fear of reprisals in civil lawsuits.

Prior to the passage of HCQIA, vigorous peer review was discouraged by the looming specter of litigation. Congress found that "[t]he threat of private money damage liability under [state and] Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." § 11101(4). Accordingly, HCQIA provides that peer review participants meeting certain fairness requirements shall not be liable under any state or federal law for damages. § 11111(a)(1).

HCQIA also requires health care entities to report disciplinary actions to a national clearinghouse established to collect and disseminate information on health care providers. §§ 11133-34. The Act then requires a hospital to obtain a physician's records from the clearinghouse prior to granting medical staff privileges. § 11135. These reporting requirements "restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." § 11101(2). Congress recognized that troubled physicians, now unable to hide their problems, would likely challenge peer review actions in the courts. *See* H.R. Rep. 99-903, at 3, *reprinted in* 1986 U.S.C.C.A.N. at 6385. The reporting requirements, therefore, heightened even further the need to protect peer review participants from civil damages.

For purpose of the immunity protection set forth in § 11111(a), a professional review action must be taken --

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) **after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances,** and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

§ 11112(a) (emphasis added).

Importantly, HCQIA creates a rebuttable presumption of immunity: "A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in § 11111(a) of this title *unless the presumption is rebutted by a preponderance of the evidence.*" §§ 11112(a), (a)(4) (emphasis added). Additionally, HCQIA expressly provides that "nothing in [§ 11112] shall be construed as -- precluding an immediate suspension or restriction of clinical privileges,

subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual." §§ 11112(c), (c)(2).

Argument

I. The Fourth Circuit's Opinion Correctly Applied Established Law and Does Not Create a Conflict with Decisions of the Third, Fifth, Eighth, and Ninth Circuits.

Wahi contends that the Opinion conflicts with four other circuits because it failed to apply a § 11112(c)(2) analysis. This argument lacks merit. The Opinion correctly holds that subsection (c) need not be addressed here because the Respondents are entitled to immunity for having complied with the reasonableness requirements of § 11112(a). *Wahi*, 562 F.3d at 614. This well-reasoned decision is consistent with the plain language and clear intent of HCQIA and does not conflict with any holding of a sister circuit.

A. The Possibility of "Imminent Danger" is Not Required for Entitlement to HCQIA Immunity Under § 11112(a), and the Fourth Circuit Did Not Err by Declining to Conduct a § 11112(c)(2) Analysis

As pointed out by the Fourth Circuit, the Respondents have never sought immunity under the "health emergencies" provision of § 11112(c)(2). Rather, the Respondents claim immunity for having

afforded Wahi reasonable procedures as set forth in § 11112(a)(1)-(4). Both the district court and the Fourth Circuit agreed that the Respondents satisfied the requirements of subsection (a) and, therefore, did not even consider whether immunity was proper under subsection (c)(2).

Wahi's Petition is built upon the false premise that his suspension must be treated as "immediate" within the meaning of § 11112(c)(2), having been handed down, he argues, before fair procedures were afforded him. Wahi recklessly argues that the Fourth Circuit "conceded" that he "was suspended immediately" and "held that the hospital could ignore the 'imminent danger' requirement and still obtain immunity if it *later* 'me[t] the usual standard' of providing notice and a hearing or other fair procedures." (Pet. at 1). This is a funhouse mirror reading of the Opinion, which clearly holds that fair procedures were provided to Wahi both *before* and after his suspension.

Having rewritten the Opinion, and having completely mischaracterized its reasoning, Wahi then pronounces it "indefensible" and "obviously flawed." (Pet. at 2). Wahi's indictment continues: "In other words, under the decision below, a doctor can be immediately suspended – without any 'imminent danger' – so long as the hospital provides some procedures at some point." (Pet. at 1-2). This is simply not what the Fourth Circuit held. Indeed, the Opinion expressly recognizes that "[u]nder subsection (a)(3), a health care entity seeking HCQIA immunity must act 'after adequate notice and hearing procedures are afforded to the physician

involved *or* after such other procedures as are fair to the physician under the circumstances.'" *Wahi* at 608 (citing 42 U.S.C. § 11112(a)(3)) (emphasis by italics in original, emphasis by underline added).

Wahi also ignores the Opinion's detailed discussion of the facts leading up to his July 30, 1999, suspension, including that:

- Information was received as early as July 8, 1999, that Wahi had performed a surgical procedure not permitted under the terms of his provisional privileges and that he had failed to notify CAMC, as required by the Bylaws, that he had voluntarily relinquished his privileges at another hospital. *Wahi*, 562 F.3d at 602;

- The Credentials Committee thereafter prompted an investigation into these charges. *Id.*;

- By letter dated July 16, Wahi was informed of the charges and the investigation, was asked to respond to each charge in writing as soon as possible, and was provided the relevant Bylaws pertaining to the charges. *Id.* at 603;

- Wahi apparently learned of the allegation that he had performed an unauthorized surgery prior to July 15, because on that date he wrote [redacted] explaining his decision to perform the procedure and why he believed it fell within his privileges. *Id.* at 610;

- Between July 16 and July 30, Wahi met with [redacted] to discuss the charges, and additional information needed to consider his responses, and wrote to the Credentials Committee Chairman to provide his side of the story. *Id.* at 603;

- Between July 16 and July 30, "Wahi wrote to [redacted] and [redacted] several times, addressing the charges in writing, and providing documents supporting his position that he had not violated the conditions of his clinical privileges." *Id.* at 610.

Thus, the Opinion concludes: **"The record shows that CAMC provided Wahi with notice of the most recent allegations against him, and an opportunity to respond to those allegations."** *Id.* (emphasis added). It was not until July 30, after Wahi had been provided with notice and an opportunity to respond, that his privileges were suspended for the "best interest of patient care."[5] The Fourth Circuit in no way conceded, as Wahi asserts, that he was afforded fair procedures *only after* his suspension.

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[5] The Fourth Circuit also engaged in a detailed discussion and analysis of the facts subsequent to Wahi's July 30, 1999, suspension. This was prompted at least in part by Wahi's primary argument on appeal that CAMC could not qualify for immunity because it **never** provided him with a hearing. Given that posture on appeal, the Fourth Circuit correctly looked at and considered all of the procedures and activities surrounding the July 30, 1999, suspension and determined that all of the procedures afforded, both before and after the suspension, were fair under the circumstances.

The Petition also presumes that no summary suspension can possibly satisfy the other fair procedures prong of § 11112(a)(3). No support for this position is found in HCQIA, and no court has ever held this to be so. Further, Wahi's argument is illogical. The determination of whether a peer review action is taken after fair procedures have been afforded must be based upon the facts. Because a suspension is handed down summarily does not mean that the suspension was taken without "other fair procedures" having been first afforded. The present case proves the point. It is undisputed that CAMC received complaints, investigated the complaints, and provided Wahi with notice of the complaints and an opportunity to respond before suspending him. Thus, the Fourth Circuit's holding that Wahi's suspension was taken after fair procedures had been afforded is well supported. Wahi simply ignores this clearly articulated basis for the Opinion.[6]

Having qualified for immunity under subsection (a), the question of whether Respondents also qualify for immunity under subsection (c) is of no consequence. This is precisely the reasoning the Fourth Circuit used to reach its conclusion that the "imminent danger" element of subsection (c)(2) was not implicated here:

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[6] Respondents submit that the district court and Fourth Circuit had no difficulty reading and understanding the language of subsection (a)(3) – and that the Opinion clearly and correctly holds that Wahi was provided fair procedures before being suspended. Ironically, in an effort to paint the Opinion as "rewriting" HCQIA, the Petitioner decidedly rewrites the Opinion.

> Subsection (c) . . . sets out distinct ways in which a health care entity can be immune under the HCQIA without having complied with the usual requirements for claiming immunity. Wahi would have us read the statute by ignoring this clear purpose and instead find that the HCQIA immunity is barred by failing to meet one of the subsection (c) prongs. To the contrary, subsection (c) presents additional routes to HCQIA immunity beyond that set forth in subsection (a)(3).

Wahi, 562 F.3d at 608. This reasoning is sound, consistent with both the letter and spirit of HCQIA, and creates no conflict with the decision of another court.

B. The Opinion Does Not Create a Conflict with the Decisions of Other Circuits

Wahi's argument that a summary suspension, by definition, cannot satisfy the "fair procedures" element of (a)(3) is unsupported by the language of HCQIA and finds no support in the case law. The courts considering immunity in this context have consistently looked to the facts to determine whether immunity is proper under subsection (a) or (c), or both. A review of the four circuit decisions Wahi *incorrectly* claims are in conflict with the Opinion illustrates the point.

Poliner v. Texas Health Systems

The *Poliner* court confronted an appeal from a judgment in favor of the plaintiff, following a jury trial. The question on appeal was whether the temporary restrictions of privileges handed down during an investigation of Dr. Poliner enjoyed HCQIA immunity as a matter of law. *Poliner v. Texas Health Systems*, 537 F.3d 368, 369 (5th Cir. 2008). The *Poliner* decision reversed and rendered judgment for the defendants, holding that they were immune from money damages as a matter of law. *Id.* at 370.

Temporary restrictions were imposed on Poliner after questions were raised regarding his treatment of "Patient 36," who presented to the emergency room on May 12, 1998, suffering from a heart attack. The Chairman of the Internal Medicine Department learned of Patient 36 the next day and decided to seek a temporary restriction of Poliner's cath lab privileges to allow for an investigation. He neither conferred with nor notified Poliner before making this decision. Later the same day, the Chairman met with Poliner and presented him with the option of consenting to an abeyance of his privileges, or being suspended. This meeting was followed with a May 14 letter repeating Poliner's options, requesting his response by 5:00 p.m. that day, and informing him of how the investigation would move forward. Poliner requested more time to consult a lawyer, but this request was denied. Poliner then signed the abeyance. *Id.* at 372.

The same basic "agree or be suspended" proposition was placed before Poliner again on May 29 in the form of a letter requesting a voluntary extension of the abeyance. The letter advised Poliner that the extension was investigational in nature and that the ad hoc committee had reviewed 44 of his cases. The letter also stated that Poliner would have an opportunity to meet with the Internal Medicine Advisory Committee to respond to the ad hoc committee review. Poliner signed the extension request. *Id.* at 373.

The *Poliner* court evaluated whether the defendants were entitled to HCQIA immunity for the May 14 abeyance and the May 29 extension, which it treated as separate professional review actions. The court held that the defendants were entitled to immunity for the May 29 extension under both subsections (a) and (c) of 11112: "We conclude that the extension of the abeyance falls within section 11112(c)(2)'s curtilage, ***and in any event,*** **defendants imposed the restriction *after* procedures that were fair to Poliner under the circumstances.**" *Id.* at 382 (emphasis added).

The *Poliner* decision continues:

> Our review . . . further leads us to conclude that the extension was imposed "after such other procedures as are fair to the physician under the circumstances." The May 14 letter provided notice to Poliner of the peer review, which patient triggered it, the other patients then-of concern, that an ad hoc Committee review would be taken and a

> general description of how that review would be conducted . . . .

Id. at 383. The Court also noted that "Poliner and his lawyer knew what was happening and why before the extension."[7] *Id.*

As it did with the facts before it, there can be little doubt that the *Poliner* court would have found immunity for the Respondents in the present case under subsection (a) or (c), or both:

> It is difficult to conceive of a meaningfully different response from Defendants. Upon receipt of the ad hoc committee's review, it would have been untenable to restore full privileges while a hearing was scheduled and Poliner was given time to prepare. Had Defendants immediately held a hearing, there would have been no opportunity for Poliner to review the cases at issue, and we have no doubt that we would be considering whether such a hearing was "fair."

Id. at 383-384. The court concludes by reiterating: "Poliner received 'fair' procedures under these

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[7] Like the Fourth Circuit in the present case, the *Poliner* court also discussed the procedures afforded to Poliner after the May 29 extension in reaching its determination of whether that professional review action enjoyed immunity. Specifically, the court pointed out that Poliner was given an opportunity to meet with the Internal Medicine Advisory Committee in person to clarify any concerns. *Id.* at 372.

circumstances." *Id.*[8] The *Poliner* decision in no way promotes Wahi's arguments.

Sugarbaker v. SSM Health Care

The *Sugarbaker* decision invokes subsection (c)(2) as the primary grounds for finding that HCQIA immunity was properly granted – and, in doing so, holds the "imminent danger" requirement of subsection (c)(2) was easily satisfied. However, *Sugarbaker* also found the summary suspension justified because the hospital followed its medical staff bylaws, which permitted a precautionary suspension in the best interest of patient care, and because "the Executive Committee imposed the precautionary suspension only after the Surgery Review Committee's review of 24 of Dr. Sugarbaker's surgical cases raised concerns with respect to Dr. Sugarbaker's practice." *Sugarbaker v. SSM Health Care,* 190 F.3d 905, 917 (8th Cir. 1999). Only after these comments did the court add: "*Furthermore*, under the HCQIA's emergency provisions, summary suspensions . . . do not result in the loss of immunity 'where the failure to take such action may result in an imminent danger to the health of any

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[8] The *Poliner* decision further found: "The interplay of these provisions may work hardships on individual physicians, but the provisions reflect Congress' balancing of the significant interests of the physician and 'the public health ramifications of allowing incompetent physicians to practice while the slow wheels of justice grind.' Defendants satisfied the notice and hearing requirements, and no reasonable jury could conclude otherwise." *Poliner* at 384 (quoting *Rogers v. Columbia/HCA of Cent. La., Inc.*, 971 F. Supp. 229, 236 (W.D. La. 1997). "At the least, it is not our role to reweigh this judgment and balancing of interests by Congress." *Id.* at 385.

individual.'" *Id.* (citing 42 U.S.C. § 11112(c)(2)) (emphasis added).

A fair reading of *Sugarbaker* leads to the conclusion that the Eighth Circuit would have upheld the granting of summary judgment in the instant case under either subsection (a) or (c). Indeed, the court made it absolutely clear that it does not view HCQIA as a statute that should be strictly construed for the benefit of physicians seeking money damages:

> Even assuming arguendo that Dr. Sugarbaker has uncovered a statutory anomaly whereby various definitions contained in the HCQIA do not dovetail perfectly together, we are persuaded that Dr. Sugarbaker's selective reading of the statute cannot stand because it would undermine Congress' clear intent in enacting the statute. When the HCQIA is viewed as a whole, there is no doubt that Congress intended to improve the quality of our nation's healthcare by encouraging professional self-regulation. Accepting Dr. Sugarbaker's asserted statutory construction would seriously undermine Congress' intent . . . .

Id. at 917 (internal citations omitted). Nothing about the *Sugarbaker* decision conflicts with the Fourth Circuit's Opinion.

Fobbs v. Holy Cross Health System Corp.

Wahi's reliance on the *Fobbs* decision is puzzling. The *Fobbs* decision reinforces the Fourth Circuit's holding that immunity can be found under subsections (a) or (c). When read in conjunction with the published opinion from the United States District Court for the Eastern District of California (which it must be to make sense in the context of Wahi's Petition), the *Fobbs* decision clearly recognizes that the "other fair procedures" requirement of (a)(3) can be satisfied in a summary suspension context. *Fobbs v. Holy Cross Health Sys. Corp.*, 29 F.3d 1439 (9th Cir. 1994).

The peer review action at issue in *Fobbs* (the imposition of monitoring and consultation restraints on Fobbs' privileges to perform intra-abdominal laser surgery) was carried out without any notice or opportunity to be heard. *Fobbs v. Holy Cross Health Sys. Corp.*, 789 F.Supp. 1054, 1056 (S.D. Cal. 1992). In considering whether HCQIA immunity attached, the district court conducted an analysis under subsection (a)(1)-(4).

In its discussion of subsection (a)(3), the court notes "[p]laintiff also argues that defendants' manner of giving him notice that his privileges were restricted after the fact was not fair. In other words, he contends that, barring an emergency 'threatening imminent danger to the health of any individual,' process was due before defendants restricted his privileges." *Id.* at 1068 (emphasis added). *This is precisely Wahi's argument.* The district court disagreed: "There is no dispute that plaintiff was

given notice of the JRC [Judicial Review Committee] hearings. Therefore the question is whether or not the JRC hearings provided adequate procedure." *Id.*

The district court notes that the hospital's first two JRC proceedings were inadequate (Dr. Fobbs was not allowed to conduct voir dire of the JRC members), but places great weight on the fact that the hospital recognized this defect and agreed to provide a third hearing: "The court is satisfied that plaintiff was given the opportunity to adequate process, but that he opted not to exercise his right thereto." *Id.* Accordingly, it is clear that the district court looked at the totality of the circumstances and determined that the requirements of subsection (a)(3) were met.[9]

On appeal, the Ninth Circuit stated: "**We affirm the district court's order with the following addition to its opinion**, which affects section V.A.3. set forth on pages 1067 and 1068 relating to whether the summary monitoring restraints prior to any notice or hearing violated the HCQIA."[10] *Fobbs*, 29 F.3d 1439 at 1442 (emphasis added). The Ninth Circuit then discussed why the defendants were also entitled to immunity under subsection (c)(2), ultimately finding that "[t]he

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[9] The district court undertook a short discussion of (c)(2) as well upon defendants' argument that they were also entitled to immunity under that subsection. However,. the district court's analysis was primary one of whether the procedures provided were fair given the particular circumstances.

[10] Section V.A.3.a set forth on pages 1067 and 1068 relates to the district court's discussion regarding subsection (a)(3) found on those pages.

defendants had ample medical justification to take the steps. The district court correctly granted defendants HCQIA immunity with respect to the summary monitoring restrictions." *Id.* at 1443.

Importantly, the Ninth Circuit did not overturn or in any way criticize the district court's analysis under (a)(3), or its finding that fair procedures were afforded to Fobbs under the circumstances. The Ninth Circuit likewise did not correct or criticize the fact that the district court placed great weight upon the fact that Fobbs was provided with the opportunity for an appeal hearing, but declined to avail himself of that opportunity. Therefore, the only reasonable conclusion is that the Ninth Circuit would endorse both the reasoning and ultimate finding of the Fourth Circuit in this case.

Brader v. Allegheny General Hospital

Nothing about the *Brader* decision suggests that the Third Circuit would have reached a different result on the question of HCQIA immunity under the facts of this case. In its "adequate notice and hearing procedures" analysis, the *Brader* court found that the district court had incorrectly concluded that questions of fact existed concerning HCQIA immunity, because the evidence, taken in a light most favorable to Brader, did not rebut that he had received ample notice and hearing procedures. The court specifically held: "For us to conclude otherwise would be to tie the hands of hospitals and force every informal review activity of a doctor or a department into time-consuming and (depending on the outcome of the informal review) possibly

unnecessary formalized proceedings." *Brader v. Allegheny General Hospital*, 167 F.3d 832, 842 (3d Cir. 1999).

Although the *Brader* court did reference § 11112(c)(2) with respect to one professional review action taken on the spot, without any warning,[11] it did not treat all pre-hearing actions taken against Dr. Brader under subsection (c). Rather, it placed considerable weight on the fact that the hospital provided advance warning to Dr. Brader regarding actions to be taken and informed him of his rights at that time, including his right to *request a hearing*.[12] In conclusion, the court held:

> that Brader has failed to rebut the presumption that AGH met the requirements for immunity under the HCQIA. He has failed to come forth with

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[11] "The one instance in which AGH did not give Brader advance warning before an adverse action was taken was when Magovern summarily suspended his AAA privileges. However, Magovern's action is covered by § 11112(c), which provides that the procedures of § 11112(a)(3) do not preclude 'an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual'" *Brader*, 167 F.3d at 842 (citing 42 U.S.C. § 11112(c))

[12] "AGH gave Brader notice of each professional review action to be taken, informing him of his due process rights and the time in which he had to request a hearing. See § 11112(b)(1). The same day that the EC decided to recommend that Brader not be advanced to full staff and that all of his privileges be suspended, Sanzo, the Hospital president, wrote to Brader, informing him of his right to seek hearings on these recommendations." *Id.*

> sufficient evidence to allow a reasonable jury to conclude that the Hospital did not provide him with adequate and appropriate procedures, or that AGH did not act at all times in the reasonable belief that its actions would further quality health care. The grant of summary judgment to AGH will therefore be affirmed.

Id. at 843. The Fourth Circuit's Opinion does not conflict with the *Brader* decision.

C. Adopting Petitioner's Proposed Statutory Framework Would Not Change the Outcome of this Case Because the Respondents Are Also Entitled to Summary Judgment on the Question of HCQIA Immunity Under § 11112(c)(2)

Wahi argues that this case would be suitable for summary reversal because Respondents concede that they suspended him without a prior finding that he posed an imminent danger. (*See* Pet. at 2, 25-26). Not so. While Respondents do argue that they qualify for immunity pursuant to § 11112(a) and need not satisfy the "imminent danger" element of subsection (c)(2) to preserve that immunity -- Respondents do not concede that the requirements for immunity under subsection (c)(2) were not met.

Wahi's construction of subsection (c)(2) is tortured in several respects.[13] First, nothing about the subsection requires a "finding" of imminent danger as Wahi asserts. Thus, Wahi's primary argument that immunity cannot attach because the hospital did not pronounce him an "imminent danger" before suspending him is unavailing.[14] Subsection (c)(2) requires merely that the failure to act "*may* result in an imminent danger to the health of any individual." *Brader*, 167 F.3d at 842; *Sugarbaker*, 190 F.3d at 917; *Poliner*, 537 F.3d at 383; *Fobbs*, 29 F.3d at 1442-1443. No reasonable jury could conclude that a possibility of imminent danger did not exist in this case. Moreover, even if a finding or pronouncement of imminent danger was required, the suspension of Wahi's privileges was expressly handed down "in the best interest of patient care" -- in other words, to protect patients. This may be a distinction, but there is no real difference.

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[13] Wahi's arguments, taken as a whole, attempt to turn subsection (c)(2) on its head and create an additional hurdle to immunity. Subsection (c)(2) is clearly intended to provide additional protection to the peer review actor, its purpose being to forgive contemporaneous compliance with the fair procedures requirement of (a)(3) where immediate action is needed. It is intended to expand immunity, not limit it.

[14] Wahi's factual arguments concerning the application of subsection (c)(2) are also suspect. Wahi points out that he was allowed to care for two patients still in the hospital after his suspension, but ignores that this was only for one day, and that he was not permitted to perform additional surgeries. In any event, while it may be true that Dr. Wahi's continued care of two patients for another twenty-four hours did not present a risk of imminent harm to those patients, it does not follow that failing to suspend his privileges would not have created a risk of harm *to any individual*.

It strains the patience of reasonable minds to suggest that Congress did not intend for immunity to be afforded to peer review actions taken to address lack of compliance with restrictions placed on clinical privileges under the circumstances present here. A cardiothoracic surgeon with Wahi's troubled track record, operating outside the scope of his surgical privileges, undoubtedly presents the type of danger to patients that prompted the inclusion of a provision which grants immunity for "immediate" suspensions. This is also the type of danger to the public that HCQIA immunity was generally intended to stop by fostering vigorous peer review. Therefore, Respondents are entitled to summary judgment under a proper § 11112(c)(2) analysis.

II. THE OPINION DOES NOT DEEPEN OR WIDEN A RECOGNIZED CIRCUIT SPLIT OR CREATE A CONFLICT WITH THE FIRST AND TENTH CIRCUITS REGARDING WHETHER THE QUESTION OF HCQIA IMMUNITY CAN BE DECIDED BY A JURY

A. The Opinion Does Not Deepen or Widen a Recognized Circuit "Split"

Wahi argues incorrectly that the Opinion "deepens a pre-existing and acknowledged split" over the availability of jury trials to determine federal immunity. (Pet. at 26). The only conflict that arguably exists between the circuits regarding the "availability of jury trials" relates to who acts as the fact-finder on the immunity issue at trial. *See Singh v. Blue Cross/BlueShield of Mass., Inc.*, 308 F.3d 25,

33-36 (1st Cir. 2002). Having found that summary judgment was correctly granted, the Fourth Circuit did not reach this issue. Accordingly, the Opinion does not "deepen" or "widen" this conflict.

B. The Opinion Applies the Accepted Test for Summary Judgment under § 11112(a) and Does Not Establish a "No Jury" Standard

Wahi's indictment of the Opinion as effectively denying a jury trial is off the mark. The Fourth Circuit applied the well-settled summary judgment test to uphold the district court's determination that the Respondents were entitled to immunity under HCQIA. In fact, the Opinion applies precedent in the Fourth Circuit, citing to *Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255, 260 (4th Cir. 2001) and *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030 (4th Cir. 1994) *Wahi, 562 F.3d* at 607.

Wahi argues that "[a]ccording to the Fourth Circuit, whether the procedures were 'fair * * * under the circumstances' was an exceedingly close question." (Pet. at 27). Wahi's arguments mischaracterize the Opinion and ignore the facts. While the Opinion acknowledges some arguable missteps, it makes no finding of wrongful conduct on the part of the Respondents. The opposite is true.

In considering Wahi's appeal of the district court's denial of his claims for *injunctive* relief (which are not subject to HCQIA immunity), the Fourth Circuit held that Wahi was entitled to no remedy because he had no "viable claim that CAMC

committed a wrong."[15] *Wahi*, 562 F.3d at 615. The Fourth Circuit concluded, therefore, that "Wahi has not made the requisite showing for any of the claims for which the district court determined the HCQIA immunity applied." *Id.* In short, the Fourth Circuit found that Wahi failed to demonstrate any wrongful conduct by the Respondents which would entitle him to any relief.

Wahi's claim that the Fourth Circuit found the question of whether fair procedures were afforded "exceedingly close" -- and simply "purported to break the tie" by invoking the presumption of immunity -- has no merit. Consistent with its own precedent, and the precedent of its sister circuits, the Opinion simply holds that Wahi failed to provide evidence upon which a reasonable jury could find that the procedures afforded to him were not fair under the circumstances. In doing so, it breaks no new ground, creates no conflict, and does not establish a "no jury" standard.

C. The Opinion Does Not Create A Conflict with Decisions of the First and Tenth Circuits

In support of his claim that the Opinion wrongfully denies him a jury trial on the question of immunity and creates a conflict between the circuits, Wahi cites to *Singh* and *Brown v. Presbyterian Health Care Services*, 101 F.3d 1324 (10th Cir. 1996). These cases do not support Wahi's arguments.

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[15] Petitioner has not challenged this finding as error in his Petition, nor has he addressed it in any manner.

Singh v. Blue Cross/Blue Shield of Mass.

As the Fourth Circuit did here, the *Singh* Court applied the well-established summary judgment test for HCQIA immunity under § 11112(a):

> In considering the defendants' motions for summary judgment based on HCQIA immunity, we ask the following: "might a reasonable jury, viewing the facts in the best light for [Dr. Singh], conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of *§ 11112(a)*?" *Austin, 979 F.2d at 734* (*Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 254, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986)*); see also *Bryan, 33 F.3d at 1333* (quoting this language from Austin). Therefore, Dr. Singh can overcome HCQIA immunity at the summary judgment stage only if he demonstrates that a reasonable jury could find that the defendants did not conduct the relevant peer review actions in accordance with one of the HCQIA standards.

Singh, 308 F.3d at 32.

Ironically, Dr. Singh (like Wahi here) argued that the award of summary judgment wrongly denied him a jury trial regarding the reasonableness issues under HCQIA. The *Singh* court soundly rejected this argument:

In asserting that the district court deprived him of his right to a jury trial with its summary judgment ruling, Dr. Singh overlooks the import of Congress's adoption of objective standards for the HCQIA immunity determination. Given the objective standards set forth in the statute, reasonableness determinations under the HCQIA may often become legal determinations appropriate for resolution by the judge at summary judgment. If there are no genuine disputes over material historical facts, and if the evidence of reasonableness within the meaning of the HCQIA is so one-sided that no reasonable jury could find that the defendant health care entity failed to meet the HCQIA standards, the entry of summary judgment does no violence to the plaintiff's right to a jury trial.[16]

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16 The *Singh* Court further pointed out:

"Congress unmistakably recognized the usefulness of summary judgment proceedings in resolving immunity issues under the HCQIA prior to trial" and that:

> The Supreme Court has repeatedly emphasized that the qualified immunity determination should be made as soon as possible during the course of litigation. See *Id. at 815-16* (referring to the Court's holding in *Butz v. Economou, 438 U.S. 478, 508, 57 L. Ed. 2d 895, 98 S. Ct. 2894 (1978)*, that "insubstantial claims should not proceed to trial"). Like the Supreme Court in Harlow, Congress indicated in the legislative history of the HCQIA that its immunity determinations should also be made expeditiously See H R. Rep. No 99-903, at 12, reprinted in 1986 U.S.C.C A.N 6384, 6394 (stating that "these provisions [are intended to]

Id. at 33-36.

Applying this standard, the First Circuit affirmed the district court's finding of immunity for the defendant insurer and physician auditor. The court concluded that no reasonable jury could find that the defendants failed to meet the HCQIA standards. Nothing about the *Singh* decision suggests that the First Circuit would have reached a different result in this case.

Brown v. Presbyterian Healthcare Services

In *Brown*, the Tenth Circuit affirmed the district court's refusal to grant judgment as a matter of law on the question of HCQIA immunity following a trial resulting in a verdict against the defendants, holding that the evidence presented a question of fact for a jury on § 11112(a)(2). *Brown*, 101 F.3d at 1327-36. The Brown decision, like all HCQIA immunity determinations, was fact-driven. Although (based upon the facts before it) the Tenth Circuit reached a different result, it applied the same well-accepted legal test for determining whether judgment as a matter of law was warranted on the question of HCQIA immunity under § 11112 (a):

---

allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible," and anticipating that courts would "determine at an early stage of litigation that the defendant has met the *[section 11112(a)]* standards").

Singh, 308 F.3d at 35-36.

> Thus, in determining whether a peer review participant is immune under the Health Care Quality Improvement Act, the proper inquiry . . . is whether Dr. Brown has provided sufficient evidence to permit a jury to find she has overcome, by a preponderance of the evidence, any of the four statutory elements required for immunity under 42 U.S.C. § 11112(a). See, e.g., Austin, 979 F.2d at 734.

Id. at 1334 n.9.

While the *Brown* decision is not directly on point -- because the *Brown* Court was looking at subsection (a)(2) (which requires "reasonable effort to obtain the facts of the matter") instead of (a)(3) -- the *Brown* court applied the same legal standards applicable generally to questions of HCQIA immunity under § 11112(a). Given a very different set of facts, it reached a different result.

Neither *Singh* nor *Brown* holds that a jury trial is *required* on the issue of immunity under HCQIA. In fact, *Singh* did not allow the question of immunity to reach a jury. It is clear under both decisions that the determination of whether summary judgment is properly granted is driven by the facts. It is also clear that summary judgment is warranted unless, as in *Brown*, the plaintiff presents sufficient evidence for a reasonable jury to find that the action taken failed to meet at least one of the statutory elements required for immunity under subsection (a). The Fourth Circuit simply found that Wahi failed to present such evidence. Thus, nothing

in the Opinion conflicts with the holdings in either *Singh* or *Brown*.

CONCLUSION

For more than two decades, HCQIA has fostered "effective professional peer review" by providing immunity from "the threat of private money damage liability" to peer review bodies and participants who investigate and discipline troubled physicians. Having mandated in the Act that disciplined physicians be reported to a national database, Congress predicted correctly that when "faced with the certainty that they can no longer hide their past records, physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them" and file antitrust lawsuits -- *precisely as the Petitioner has done here*. H.R. Rep. 99-903, *reprinted in* 1986 U.S.C.C.A.N. at 6385. Congress further believed that those who are "sufficiently fearful of the threat of litigation will simply not do meaningful peer review," and deemed it essential, therefore, that immunity from suit be provided to peer review participants. *Id.* To this end, HCQIA provides immunity from civil damages if a professional review action meets the reasonableness standards specified in § 11112(a), and further provides a presumption that a peer review action met the standards of § 11112(a) which must be rebutted by a preponderance of the evidence. § 11111, § 11112(a)(4).

The Fourth Circuit applied the established legal test to reach its determination that Wahi failed to rebut the presumption that the Respondents were

entitled to HCQIA immunity as a matter of law pursuant to § 11112(a). The Opinion is well-reasoned and carries out the clear intent of HCQIA by protecting from civil damages those who carry out peer review. In doing so, it breaks no new ground and creates no conflict with the decision of another circuit. Accordingly, there is no compelling reason for the Petition to be granted.

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No. 09-430

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In the Supreme Court of the United States

RAKESH WAHI, M.D.,

Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

REPLY IN SUPPORT OF CERTIORARI

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REPLY IN SUPPORT OF CERTIORARI

Respondent CAMC effectively concedes all of the elements of our showing that the Court should grant the petition on both questions presented. And it offers no plausible reason why this Court should *not* grant review, or why this case is not a suitable vehicle for resolving both questions—which, as CAMC also does not dispute, are questions of great importance to the Nation's healthcare system and to the patients and doctors who participate in it.

I. CAMC offers no serious response to our showing of a conflict as to the availability of immunity for summary suspensions imposed without imminent danger.

CAMC's most important concession concerns the requirement imposed by the Health Care Quality Improvement Act ("HCQIA") that, to obtain immunity under the non-emergencies provision, "a health care entity * * * must act '*after* adequate notice and hearing procedures * * * *or after* such other procedures as are fair * * * under the circumstances.'" Opp. 16-17 (quoting § 11112(a)(3)); emphases in original). Having conceded that central premise, CAMC attempts to explain away the conflict on the first issue by claiming, initially, that the Fourth Circuit didn't actually hold that a hospital can obtain immunity under this provision based on *post*-suspension procedures. But then, after eventually conceding that the Fourth Circuit *did* so hold, CAMC argues (contradicting its position below) that the holding doesn't really matter because the Fourth Circuit *could* have ruled on the basis of the emergencies provision. Neither argument undermines

our showing that this Court should grant review of the first question presented.

1. In immunizing CAMC, as we showed, the Fourth Circuit relied extensively on procedures purportedly offered to Dr. Wahi after his suspension. Pet. 15-16, 18. To be sure, *before* the suspension, as CAMC points out (at 17-18), CAMC and Dr. Wahi exchanged letters and held some informal meetings. But at that point CAMC did "not mention a possible suspension." Pet. 22a. To the contrary, CAMC "scheduled a meeting with Wahi for August 3, 1999," Pet. 6a, but then suspended him on July 30—five days before the meeting, *ibid.* On that day, CAMC notified Dr. Wahi that his privileges were "hereby summarily suspended." *Ibid.* It is no wonder, then, that the Fourth Circuit, the district court, and CAMC itself consistently describe Dr. Wahi's suspension as "summary." Pet. 45a ("summary"); Pet. 6a, 12a ("summarily"); Opp. 1, 8, 19 ("summary," "summarily," "summarily").

Given the summary character of Dr. Wahi's discipline, it is not surprising that the Fourth Circuit relied heavily on procedures allegedly provided *after* the suspension. In contrast to the two paragraphs devoted to Dr. Wahi's pre-suspension interactions with CAMC, the court devoted twelve paragraphs to the period post-suspension. See Pet. 23a-31a. And ultimately, the court held that any pre-suspension infirmities were cured by offering Dr. Wahi a hearing *after* the suspension: "Had Wahi proceeded to a [post-suspension] hearing, any complaint about the inadequacy of notice, defective witness list or discovery, the composition of the hearing panel, the conduct of the hearing, or other relevant issues could

have been addressed and subjected to judicial review." Pet. 30a.

Indeed, so heavy was the Fourth Circuit's reliance on post-discipline process that even CAMC ultimately concedes that it was part of the court's holding. "The Fourth Circuit also engaged," CAMC admits, "in a detailed discussion and analysis of the facts *subsequent* to Wahi's July 30, 1999 suspension," and "clearly *holds* that fair procedures were provided to Dr. Wahi both before *and after* his suspension." Opp. 18 n.5, 16 (some emphasis omitted; other emphasis added); see also *id.* at 18 n.5 (court below "considered all of the proceedings * * * before *and after* the suspension") (emphasis added).

2. Under the HCQIA's non-emergencies provision, however, immunity for summary discipline cannot be based even partially on post-discipline procedures. The statute forbids it. Again, as CAMC admits, "a health care entity seeking HCQIA immunity must act '*after* adequate notice and hearing procedures are afforded to the physician involved *or after* such other procedures as are fair to the physician under the circumstances.'" Opp. 16-17 (quoting § 11112(a)(3); emphases in original).

Of course, there *is* an HCQIA provision that provides immunity based on procedures "subsequent" to the discipline: the "emergencies" provision. § 11112(c)(2). That provision, however, requires the presence of possible "imminent danger." *Ibid.* But as the Fourth Circuit itself pointed out, [redacted]

[redacted]*

CAMC's own concessions thus establish that the Fourth Circuit simply rewrote the statute. By relying on post-discipline procedures, it now grants hospitals immunity for summary suspensions that can be immunized only under the emergencies provision—yet without any showing of possible "imminent danger." This is an egregious error—worthy, if the Court so chose, of summary reversal.

3. Contrary to CAMC's assertion (Opp. 20-30), moreover, four other circuits would have come out the other way. All four hold that the HCQIA emergencies provision can be satisfied only upon a showing of possible "imminent danger"; and none conducts an analysis under the non-emergency provision using *post*-discipline procedures.

To begin with, CAMC simply ignores the holding of *Poliner*, in which the Fifth Circuit "conclude[d] that the [discipline] falls within [the emergency provision's] curtilage"—but only because the hospital was "fully warranted in concluding that failing to impose [the discipline] 'may result' in an imminent danger." 537 F.3d at 381-382. True, having found the possibility of imminent danger, the court further accepted the saving argument that the discipline had also been "imposed after such other procedures as are fair under the circumstances." *Id.* at 383 (quotations omitted). But that is unremarkable: Where a court finds a "health emergency" based on the possibility of "imminent danger" under § 11112(c)(2), lim-

* Bold brackets show material redacted by the Fourth Circuit

iting the procedures available before discipline might well be "fair" under the circumstances. See *id.*

But here, the Fourth Circuit avoided any finding of imminent danger and then simply announced that, even *without* such danger, hospitals can skimp on pre-discipline procedures so long as they offer a hearing later. As our petition explains, this turns the statute on its head. Pet. 23.

Nor does CAMC have any plausible answer to *Sugarbaker*. CAMC claims that "[a] fair reading" of that decision shows "the Eighth Circuit would have upheld the granting of summary judgment in the instant case under *either* [the non-emergencies provision] or [the emergencies provision]." Opp. 25 (emphasis added). But that's far from a "fair reading." In immunizing the hospital for the doctor's summary suspension, the Eighth Circuit did not even hint at the *non*-emergencies provision. Rather, noting the possibility of imminent danger on the facts there—which were the basis for the hospital's summary suspension—the court observed that "summary suspensions, 'subject to *subsequent* notice and hearing or other adequate procedures, do not result in the loss of immunity *where the failure to take such an action may result in an imminent danger to the health of any individual.*'" 190 F.3d at 917 (emphasis added) (quoting § 11112(c)(2)).

Thus, unlike the decision below, the Eighth Circuit did not read "after" out of the non-emergencies provision or "imminent danger" out of the emergencies provision. Instead, the Eighth Circuit acknowledged the "require[ment]" of imminent danger in the *emergencies* provision, and found it satisfied. *Ibid.*

CAMC buries in a footnote (at 29 n.11) the critical holding of another conflicting decision—the Third Circuit's decision in *Brader*. There, the doctor was "on informal notice that he might be suspended," and even told his supervisor that "the only way to prevent him from performing [the procedures in question] was to suspend him." 167 F.3d at 842 n.4. Yet the Third Circuit held that the doctor did not have "advance warning" of his suspension and thus analyzed his suspension under the emergencies provision, which it held satisfied. *Id.* at 842. Unlike the court below, the Third Circuit did not so much as mention the *non*-emergencies provision, much less rewrite the emergencies provision to justify immunity absent imminent danger.

Finally, CAMC badly misreads the history of the Ninth Circuit's decision in *Fobbs*. CAMC claims that the district court's decision primarily focused on the non-emergencies provision. Opp. 27 n.9. But in fact, the district court set out to consider both prongs of the *emergencies* provision—namely, whether the defendants "believed the [discipline] was necessary to protect patient safety" and "that they gave plaintiff adequate notice and hearing procedure after the [discipline] commenced." 789 F. Supp. at 1067. But having thus framed the issue, the district court there, like the court below, blessed the procedures as adequate without finding the possibility of imminent danger.

The Ninth Circuit corrected the oversight, holding that "[t]he record of the problems caused by [the doctor at issue] clearly supports the conclusion * * * that a summary restriction be taken to avoid imminent danger." 29 F.3d at 1443. By finding summary

procedures adequate in the *absence* of imminent danger, the Fourth Circuit thus made the same error as the district court in *Fobbs*. And the Ninth Circuit's correction of that error thus sets that court at odds with the Fourth.

In sum, CAMC has done nothing to undermine our showing that the court below created a split with four other circuits.

4. Having effectively conceded the Fourth Circuit's mistaken reading of the HCQIA, for the first time CAMC attempts to satisfy the imminent danger requirement of the *emergencies* provision. Opp. 30-32. But CAMC stops short of asserting that its late claim would prevent this Court from reaching this issue, or otherwise makes this case an unsuitable vehicle for resolving it. And the reason is that CAMC conceded below that it was *not* relying on any possibility of imminent danger (Pet. 81a), and therefore the Fourth Circuit [redacted].

At this point, of course, CAMC cannot retract its concession, which it boldly announced below in a heading in its merits brief. After making clear that it was relying on the *non*-emergencies provision, CAMC stated: "**CAMC did not violate *** HCQIA by suspending [Dr. Wahi] without a prior finding that he posed an imminent danger to patients.**" Pet. 81a (emphasis in original). And the Fourth Circuit took the cue, noting that [redacted]

Having induced the court below to adopt CAMC's position, CAMC cannot change its position without violating settled principles of judicial estoppel, *New Hampshire* v. *Maine*, 532 U.S. 742, 749 (2001), and the rule that arguments not presented below are waived, *Sprietsma* v. *Mercury Marine*, 537 U.S. 51, 56 n.4 (2002).

But even if CAMC's retraction were allowed, that would not change the *holding* of the decision below, which, as we have shown, allows summary suspensions in the absence of imminent danger. This Court's prompt review is needed to correct that error, and to resolve the resulting circuit split.

II. CAMC effectively concedes the conflict on the right to a jury trial under the HCQIA, and cannot explain why this case is not a good vehicle to resolve that conflict.

CAMC also effectively concedes the key elements of our showing that the Court should grant the petition on the second question presented. CAMC does not dispute that there is a sharp, recognized conflict among the circuits over the right to a jury trial under the HCQIA (Opp. 32-33), and cannot dispute that this case is a sound vehicle for resolving that split.

1. As shown in the petition, according to the First Circuit in *Singh*, the HCQIA "contemplates a role for the jury, in an appropriate case, in deciding whether a defendant is entitled to HCQIA immunity." 308 F.3d at 33. Only "if * * * no reasonable jury could find that the defendant * * * failed to meet the HCQIA standards [does] the entry of summary judgment do[] no violence to the plaintiff's right to a

jury trial." *Id.* at 36. In so reasoning, the First Circuit squarely rejected the Eleventh Circuit's contrary rule that, "*[u]nder no circumstances* should the ultimate question of whether the defendant is immune from monetary liability under HCQIA be submitted to the jury." *Bryan*, 33 F.3d at 1333 (emphasis added). That rule, the First Circuit observed, is in "contradiction of the other circuits' holding that a jury *may* in principle make a HCQIA immunity determination." *Singh*, 308 F.3d at 35 n.7 (emphasis added). And the First Circuit specifically identified *Bryan* as being in "contradiction" not only of its own holding in *Singh*, but also of the Tenth Circuit's decision in *Brown* v. *Presbyterian Healthcare Services*, 101 F.3d 1324, 1334 n.9 (10th Cir. 1992). CAMC cannot and does not dispute that the First Circuit has correctly identified a square circuit split.

Nor does CAMC offer any serious response to our showing that the decision below exacerbated this pre-existing split. To be sure, as CAMC points out (at 32-33), the court below did not expressly state that a jury trial is never available where a hospital invokes immunity under the HCQIA. However, as the petition explained (at 26-33), the Fourth Circuit's application of the statutory presumption of immunity—especially where the court acknowledged the very facts that would ordinarily have created a jury question on the availability of immunity—effectively guarantees that a jury trial could never be had under that court's reasoning. That usurpation of the jury's role is what First and Tenth Circuits decry, but what the Eleventh Circuit and Colorado Supreme Court require. With the addition of the Fourth Circuit to those latter two courts, the split is now 3-2—and counting.

2. Any doubt about the existence of a conflict vanishes in light of *Brown*, which CAMC cannot begin to distinguish. See Opp. 37-38. In *Brown*, unlike in the decision below, the Tenth Circuit awarded a jury trial even though the doctor had only a single expert on his side. Yet here, the Fourth Circuit *itself* found CAMC guilty of numerous "failures" and declared its conduct "not a recommended model." Pet. 30a. And CAMC does not dispute that, the day before CAMC's chief of staff suspended Dr. Wahi, that same chief of staff *exonerated* him. Pet. 10. Nor does CAMC dispute that Dr. Wahi has been exonerated three times by the West Virginia Board of Medicine. Pet. 13 .

Those facts—from which a jury could easily rebut the statutory presumption of good faith—would undoubtedly have been sufficient to create a right to jury trial under the analysis in *Brown*. Indeed, as *Brown* recognized, to deny a jury trial on such facts would be to act "in direct contravention to Congress' intention" and "abrogate the jury's responsibility to weigh the evidence and determine the credibility of witnesses." 101 F.3d at 1334 n.9.

In short, there is a glaring and undeniable conflict between the approaches of the Tenth and Fourth Circuits, not to mention the acknowledged pre-existing conflict between the First and Eleventh Circuits.

3. Nor can there be any doubt that this case is a good vehicle for resolving the conflict. As explained, at least one Circuit—the Tenth, which required a jury trial on the facts there—clearly would have required a jury trial on the facts here. But even if this Court were to conclude that a jury trial were *not* re-

quired here, that would not prevent the Court from holding that the HCQIA does not *per se* exclude jury trials, and thereby overruling the contrary express conclusion of the Eleventh Circuit, and the contrary implicit conclusion of the court below. This case is thus an appropriate vehicle to resolve the split acknowledged by the First Circuit, and widened by the decision below.

III. CAMC cannot dispute that sham peer review is a national problem, and its own discredited allegations against Dr. Wahi highlight the seriousness of that problem.

Finally, CAMC offers no answer to petitioner's and *amici*'s showing that the decision below will exacerbate the national problem of hospital-manipulated peer review. Instead, CAMC attempts (at 4-8) to smear Dr. Wahi with self-serving and irrelevant allegations (see Pet. 4a, 44a). But those allegations are false, and merely highlight the need for this Court's intervention.

While space does not permit a full refutation of CAMC's allegations, CAMC does not dispute three facts that powerfully show Dr. Wahi's excellence as a physician, and the true context for this lawsuit:

- Based on the very charges leveled in CAMC's opposition, Dr. Wahi was investigated three times by the impartial West Virginia Board of Medicine and was exonerated every time. Pet. 13.
- CAMC's own investigation exonerated Dr. Wahi, concluding that Dr. Wahi's treatment "did *not* fall outside of his delineated clinical privileges." Pet. 10 (emphasis added).

- CAMC's investigations of Dr. Wahi began *after* he began exploring an association with surgeons at a neighboring hospital, JA 967, and CAMC later entered a consent decree with the United States pledging to halt further anti-competitive conduct in Dr. Wahi's own department, PFN 28.

Finally, as to Dr. Wahi's purported suspension by another hospital, CAMC fails to mention that this suspension was triggered by CAMC's *own* investigation, which ultimately vindicated Dr. Wahi. See JA 730, 964. CAMC's reliance on that suspension is simply one more indication that hospitals cannot be entrusted with the kind of blanket immunity that the Fourth Circuit held was required by the HCQIA.

CONCLUSION

In sum, the Fourth Circuit has bent the HCQIA beyond the breaking point. In the process, the court split the circuits on one issue and further splintered them on another. Accordingly, if the Court does not summarily reverse, it should take this opportunity to resolve these conflicts and encourage healthy competition by skilled surgeons like Dr. Wahi—competition critical to controlling healthcare costs and ensuring the best possible patient care.

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IN THE

Supreme Court of the United States

RAKESH WAHI, M.D.

Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *ET AL.*,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONER AND BRIEF OF *AMICUS CURIAE* ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

Pursuant to Rule 37.2(b) of the Rules of the Supreme Court, the Association of American Physicians and Surgeons, Inc. ("AAPS") respectfully moves this Court for leave to file the accompanying brief *amicus curiae* in support of the Petition for Writ of Certiorari submitted by Petitioner Rakesh Wahi. Respondents have not granted consent, thereby making this motion necessary.

AAPS is a non-profit, national group of thousands of physicians founded in 1943, dedicated to defending the patient-physician relationship and free enterprise in medicine. AAPS has filed *amicus curiae* briefs in several federal appellate cases concerning sham peer review, and on many other important medical issues. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 933 (2000) (citing an AAPS *amicus* brief); *Springer v. Henry*, 435 F.3d 268, 271 (3d Cir. 2006) (citing an AAPS *amicus* brief in the first paragraph of the decision); *United States v. Rutgard*, 116 F.3d 1270 (9th Cir. 1997) (reversal of a sentence as urged by an *amicus* brief submitted by AAPS).

There is a growing misuse of peer review commonly known as "sham peer review." Sham peer review consists of manipulation of peer review to eliminate physicians for economic or other improper reasons. Accountability for wrongdoing is essential to deter and guard against sham peer review, and the lower court's standard for immunizing such wrongdoing by hospitals with respect to physicians has a disastrous effect on health care. AAPS has members who have been injured by bad faith or "sham" peer review, simi-

lar to what has occurred here. Many good physicians have lost their ability to practice medicine, and their patients have lost their access to the physicians of their choice, because of these sham peer reviews.

The Petition has national implications for the delivery of quality medical care and the integrity of professional peer review. Patients suffer when physicians are removed from hospital staffs, and their careers ruined, based on improper motives. When immunity shields and encourages hospitals to engage in sham peer review, as occurred here, the chilling effect on good physicians is catastrophic. Few physicians will speak out in favor of patient care and preservation of life if it means risking their careers at the hands of a biased hospital committee.

AAPS submits the attached brief to explain the national significance of how the decision below unjustifiably encourages "sham peer review" by hospitals. In this brief AAPS also demonstrates the importance of restoring integrity to peer review for the benefit of medical care nationwide.

For the above reasons, AAPS respectfully requests that this motion for leave to file the attached brief *amicus curiae* be granted.

Respectfully submitted,

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Surgeons, Inc.

QUESTIONS PRESENTED

1. The Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152, provides a hospital immunity from monetary damages for disciplining a doctor "*after*" providing "adequate notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). By contrast, the Act allows disciplining "immediately" – that is, *before* notice and a hearing or other "fair" procedures – only where "failure to take such an action may result in an imminent danger to the health of any individual." § 11112(c). Did the court below err in holding, in conflict with four other circuits, that a hospital can obtain immunity for disciplining a doctor immediately – before notice and a hearing – where the hospital concedes that it did not find or rely upon the possibility of imminent danger?

2. Under the Act, may an immunity determination be made by a jury, as the First and Tenth Circuits hold, or is a jury forbidden from making such a determination, as the Eleventh Circuit and Colorado Supreme Court hold – and as the Fourth Circuit effectively held here?

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H. Friendly, "Federalism: A Foreword," 86 Yale L. J. 1019 (1977) 22

Lawrence Huntoon, M.D., Ph.D., "Tactics Characteristic of Sham Peer Review," *Journal of American Physicians and Surgeons* 64 (Fall 2009) 13-14, 17

Lawrence Huntoon, M.D., Ph.D., "Abuse of the 'Disruptive Physician' Clause," *Journal of American Physicians and Surgeons* 68 (Fall 2004) 9-10

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No. 09-430

IN THE
Supreme Court of the United States

RAKESH WAHI, M.D.

Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *ET AL.*,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

INTEREST OF *AMICUS CURIAE*[1]

The Association of American Physicians and Surgeons, Inc. ("AAPS"), founded in 1943, is a non-profit, national group of thousands of physicians. AAPS has members who have suffered from bad faith

[1] Timely notice for this brief was provided in compliance with Rule 37.2(a) of the Supreme Court of the United States. Respondents did not consent and hence an accompanying motion is filed with this brief. Pursuant to its Rule 37.6, counsel for *amicus curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amicus*, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

peer review by hospitals, also known as "sham peer review," as retaliation for competing with a hospital, practicing innovative medicine or simply standing up on behalf of patients. In many cases the sham peer reviews are initiated because a talented physician posed a competitive threat to a hospital, or to colleagues who are powerful at a hospital.

AAPS is dedicated to defending the practice of private and ethical medicine so that physicians may best serve their patients without interference by third parties. AAPS has filed *amicus curiae* briefs in numerous cases before the United States Supreme Court and federal Courts of Appeals, and its submissions have been cited in opinions. *See, e.g.*, *District of Columbia v. Heller*, 128 S. Ct. 2783, 2860 (2008) (Breyer, Stevens, Souter and Ginsburg, JJ., dissenting); *Stenberg v. Carhart*, 530 U.S. 914, 933 (2000).

The issues presented in this case are of national importance, affecting virtually every hospital in the nation, every physician at every hospital, and every one of their patients. *Amicus* has a direct and vital interest in the issues presented by the Petition, based on the harmful effect on the practice of medicine and the quality of patient care that results from judicially created – and statutorily unjustified – immunity for bad faith peer review.

SUMMARY OF ARGUMENT

Bad faith or "sham" peer review is an issue of enormous national importance. It is a pervasive national problem that impedes medical innovation, interferes with beneficial competition, and punishes extraordinarily good medical care. In no industry other than health care can a self-interested rival

thwart competition with impunity and destroy good professionals with abandon, while enjoying full legal immunity for the wrongdoing.

In this case, the Respondent Charleston Area Medical Center (CAMC) concedes it did not rely on any imminent danger in summarily suspending Petitioner Wahi's privileges. *See* Petition at 25. But imminent danger is the only legitimate and statutorily justified basis for taking such draconian, emergency action. The real motivation for the CAMC to take such drastic action was apparently just as Petitioner Wahi alleged: "CAMC's decisions to suspend [Petitioner Wahi] and deny his application for reappointment were taken in bad faith to prevent competition by monopolizing the field of cardiac surgery in the region and to prevent him from practicing medicine." *Wahi v. Charleston Area Med. Center*, 562 F.3d 599, 605 (4th Cir. 2009) (Pet. at 10a).

Sham peer review, which is at the heart of this case, works as follows. A hospital seeking to destroy a potential competitor finds a pretext for revoking or restricting the physician's medical privileges, as occurred here. That results in an entry against the physician in the National Practitioner Data Bank, as occurred here, which is the equivalent of a professional blacklist and a death-sentence to the physician's career. *Id.* at 603 (Pet. at 7a). The physician, as in the case of Petitioner Rakesh Wahi, M.D., is then unable to obtain hospital privileges *anywhere*. Physicians, who have invested the best years of their lives and hundreds of thousands of dollars in their education and training, cannot afford to risk being destroyed by sham peer review. The chilling effect of granting immunity to wrongdoing in this process is

unfathomable; it utterly destroys competition and innovation in everything affected by hospitals, which is nearly the entire health care system.

Lower courts have developed an unjustified standard that fully allows bad faith by hospitals without accountability. A hospital need only find a single mistake in the physician's practice – something all physicians have, as no one is perfect – and this satisfies the purely objective standard adopted by the courts for affirming a hospital's revocation or limitation of privileges.

In this case, the CAMC, an affiliation of seven hospitals in West Virginia, suspended Petitioner Wahi and denied his application for reappointment for one likely reason: economics rather than quality of care. The hospital's basis for denying Petitioner Wahi reappointment was *not* for a medical error, but for his provision of care (an operation) to a high risk patient. *See* J.A. 586. Hospitals intimidate physicians into withholding or rationing care from the most sickly (and most costly) patients in this manner. After all, hospitals are economic entities motivated by money as much as any other business. But only hospitals enjoy a legal standard granting them full immunity for their wrongdoing in destroying a professional. What occurred in this case is playing out in nearly every hospital in this nation, and the cost of allowing hospitals to continue to engage in bad faith peer review to suppress competition, innovation and quality care is astronomical.

The appellate court below adopted and applied a particularly "unconventional standard" to deny accountability for this sham peer review and thereby prevent Wahi from obtaining his full day in court.

The appellate court has split with other Circuits on the proper standard for reviewing allegations of bad faith peer review. This Court should grant the Petition for Writ of Certiorari to correct this especially "unconventional standard" and restore accountability for wrongdoing by hospitals which take action against professionals who may seek to compete against them, or may develop a technique that threatens the hospital's revenue, or may simply stand up for the care of patients at the hospital.

The Petition should be granted due to the national importance of this issue. The misuse by a hospital of peer review at issue in this case is pervasive in the health care industry.

The health care industry consumes one-sixth of our nation's economy and has dominated national politics for most of 2009. Costs are increasing faster than the quality of care. Basic economic principles dictate that high prices are typically the result of inadequate competition, and that is certainly the case in the profitable hospital industry. With increasing frequency, when there is even a hint of competition against a hospital by a physician on its staff, the hospital initiates a sham peer review. The precedent set below unjustifiably immunizes the hospital from accountability and liability for its bad faith in destroying potential competitors.

ARGUMENT

At issue here is the particularly "unconventional standard" adopted by the Fourth Circuit and implemented below in granting summary judgment to a hospital for destroying a professional and potential competitor through bad faith peer review. 562 F.3d

at 607 (quotations omitted). Petitioner Wahi posed a potentially competitive threat to CAMC, and it responded by summarily suspending his privileges and reporting him to the National Practitioner Data Bank, destroying his surgical career. Instead of applying the express prohibition on HCQIA immunity for summary suspensions in the absence of imminent danger, the court below upheld the hospital's discipline and prevented the issue from going to a jury.

This Court should grant the Petition for three reasons. First, there is national significance to the application below of an especially unconventional standard that immunizes bad faith peer review even when it is anticompetitive and perpetrated without a hearing or even notice. By protecting wrongdoing by hospitals in initiating peer review and falsely reporting competitors to the National Practitioner Data Bank as though they are bad doctors, the standard adopted by the appellate court worsens the chilling effect imposed by hospitals on medical innovation by potential competitors who reasonably fear retaliation.

Second, the Petition should be granted to curb growing legal abuses encouraged by judicial immunity granted to bad faith peer review of physicians. The hospital bar is increasingly relying on contrivances and sensationalism to destroy physicians who might compete with a hospital, and courts below are repeating tabloid-like allegations as though they have merit. This case features a cardio-thoracic physician as Petitioner, and despite being in a high-risk field his medical record is remarkably clean. But that did not stop the hospital from exploiting its immunity with trumped-up and almost *National Enquirer*-style allegations, which were then repeated by the court below as though they were true.

Finally, a physician's right to a hearing and, in the absence of imminent danger, adequate notice *before* suspension, are essential to deter and inhibit sham peer review. The granting of blanket immunity below in the absence of the requisite notice or a prior hearing – and not even an *ex post facto* hearing – has dire consequences for the entire health care field. The statute does not support granting hospitals such sweeping immunity for their wrongdoing against potential competitors.

Proper application of HCQIA procedures to hospital peer review arises in nearly every hospital in the nation, and affects most of the hundreds of thousands of physicians having hospital privileges. In light of the enormous national significance, the Petition should be granted.

I. A CRISIS OF NATIONAL SIGNIFICANCE RESULTS FROM THE "UNCONVENTIONAL STANDARD" APPLIED BY THE FOURTH CIRCUIT BELOW, WHICH IMPEDES COMPETITION, FRUSTRATES INNOVATION, AND INTERFERES WITH QUALITY MEDICAL CARE.

It should be axiomatic that summary suspension of a physician's privileges – which plainly has the effect of destroying his reputation and career – requires a showing of imminent danger before immunity can insulate the decision from accountability. Four Circuits have so held, and nothing in the Health Care Quality Immunity Act (HCQIA) suggests otherwise.

Yet the appellate court below split with these authorities and turned HCQIA on its head by holding otherwise. It adopted a version of a HCQIA standard that it describes as "unconventional", and its holding essentially gives hospitals *carte blanche* to destroy

any physician who might become an obstacle to hospital profits. This creates not only a circuit split,[2] but also a crisis of national significance, as no physician can be innovative or competitive without fearing an unjustified summary suspension, which is then reported to the National Practitioner Data Bank with devastating reputational effect. Such blacklisting typically permanently prevents the physician from obtaining hospital privileges again. Petitioner Wahi, a superb cardio-thoracic surgeon, has been destroyed and his patients have been deprived of his superior care.

The decision below extends a prior ruling by Fourth Circuit beyond all statutory limits, to significant national detriment. In *Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255 (4th Cir. 2001), a physician enjoyed procedural safeguards that are not present here. There the physician received a full hearing, unlike here. The "presumption of immunity" embraced by the *Gabaldoni* Court, *see id.* at 260, makes little sense where, as here, there was a summary suspension without any imminent danger and there was no subsequent hearing at all. In opening the door to meritless summary suspensions and providing full immunity to hospitals for such wrongdoing, the decision below conflicts with the other circuits and causes a problem of national significance.

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[2] The circuit splits created by the decision below are described well in Points I.B and II of the Petition. Briefly, the decision below creates a circuit split over whether HCQIA immunity attaches to a summary suspension imposed without imminent danger, and widens another split over whether HCQIA bars a jury trial.

Medical literature has frequently described the abuses perpetrated by the hospital industry against good physicians under the guise of peer review, and the aberrant decision below opens the floodgates to more sham peer review. *See e.g.*, Gail Weiss, "Is Peer Review Worth Saving?" Medical Economics (Feb. 18, 2005);[3] Steve Twedt, "The Cost of Courage: How the Tables Turn on Doctors," *Pittsburgh Post-Gazette* A1 (Oct. 26, 2003);[4] John Zicconi, "Due Process or Professional Assassination?" Unique Opportunities (March/April 2001);[5] David Townsend, "Hospital Peer Review Is a Kangaroo Court," Medical Economics 133 (Feb. 7, 2000).

Many additional medical journal articles have detailed the abuses of peer review, which continue to worsen. *See, e.g.*, William Summers, "Sham Peer Review: A Psychiatrist's Experience and Analysis," *Journal of American Physicians and Surgeons* 125 (Winter 2005);[6] Roland Chalifoux, Jr., M.D., "So What Is a Sham Peer Review?", 7 *Medscape General Medicine* (No. 4) 47 (2005); John Minarcik, M.D., "Sham Peer Review: a Pathology Report," *Journal of American Physicians and Surgeons* 121 (Winter 2004);[7] Lawrence Huntoon, M.D., Ph.D., "Abuse of the 'Disruptive Physician' Clause," *Journal of Ameri-*

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[3] http://www.memag.com/memag/article/articleDetail.jsp?id=147405 (viewed 11/6/09)

[4] http://www.post-gazette.com/pg/03299/234499.stm (viewed 11/6/09)

[5] http://www.uoworks.com/pdfs/feats/PEERREVIEW.pdf (viewed 11/6/09)

[6] http://www.jpands.org/vol10no4/summers.pdf (viewed 11/6/09)

[7] http://www.jpands.org/vol9no4/minarcik.pdf (viewed 11/6/09)

can Physicians and Surgeons 68 (Fall 2004);[8] William Parmley, "Clinical Peer Review or Competitive Hatchet Job," 36 *Journal of the American College of Cardiology* 2347 (2000).

As courts increasingly immunize hospitals for wrongdoing in peer review, the epidemic of bad faith review of potential competitors worsens. Such wrongful conduct interferes with quality medical care and impedes the benefits of competition and free enterprise. "Sham peer review" is not "peer review" at all, but is tortious conduct labeled "peer review" by hospitals in order to exploit a judicially created immunity. The decision below should be reversed to ensure that hospitals do not continue to summarily suspend physicians – thereby destroying their careers and chilling innovation and competition – without adequate basis.

In an economic sense, it is not surprising that hospital administrators hired to maximize profits would exploit their immunity for the benefit of shareholders, at the expense of patient care. And if this immunity were actually created by Congress, then the courts might leave the problem for Congress to resolve. But Congress did not create such sweeping immunity in HCQIA or any other federal law. Moreover, principles of federalism militate against such a massive interference with state law in this field.

When courts expand immunity to sham peer review the "system is too open to manipulation and needs reform." Jeff Chu, "Doctors Who Hurt Doctors," Time 52 (Aug. 15, 2005) (citing the Association of American Physicians and Surgeons). In medicine

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[8] http://www.jpands.org/vol9no3/huntoon.pdf (viewed 11/6/09)

as in any industry, a sweeping grant of immunity to one side is as disastrous as it is unjustified. For physicians who truly are a danger to patients, state medical boards can and will restrict or revoke their licenses to practice medicine. Likewise, they can weed out complaints filed under questionable motivations, such as when the West Virginia state medical board repeatedly exonerated Dr. Wahi. In addition, patients themselves will abandon a bad physician, just as shoppers will not continue buying bad products. If a hospital wishes to rid itself of a negligent physician, it is always free to do so regardless of whether it has special immunity under federal law. But immunity for sham peer review by a hospital is inappropriate.

Unchecked retaliation against innovators and outspoken physicians is a growing problem. Nearly 25% of physicians who reported concerns with patient care, which could include denial of care to handicapped infants or those in persistent vegetative states, suffered threats to their jobs. Scott Plantz, M.D., *et al.*, "A National Survey of Board-Certified Emergency Physicians: Quality of Care and Practice Structure Issues," 16 *Am. J. of Emerg. Med.* 1, 2-3 (Jan. 1998). Steve Twedt of the Pittsburgh Post-Gazette has reported on the same problem in his series beginning Oct. 26, 2003, entitled "Cost of Courage."[9] His articles showed how retaliation occurs nationwide, describing in detail the experiences of 25 physicians and a nurse, who suffered from actions adverse to their careers after they tried to improve care at their respective institutions.

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[9] http://www.post-gazette.com/pg/03299/234499.stm (viewed 11/6/09)

Dr. Harry Horner is a physician who had to fight all the way to the Supreme Court of Virginia to obtain reinstatement after retaliation for complaining about poor care at the hospital. *See Horner v. Dep't of Mental Health, Mental Retardation, & Substance Abuse Servs.*, 268 Va. 187 (2004). Though difficult to glean from the reported decision, Dr. Horner was exposing the poor care of patients when an administrator at Western State Hospital accused him of violating another employee's right to confidentiality. The administration of Dr. Horner's hospital added accusations that he was guilty of abuse and neglect because he failed to wear gloves while dressing a wound on a patient's foot. *See* Bob Stuart, "Court Rules for Whistleblower," *News Virginian* (June 16, 2004). Such pretextual allegations have become common; judicial relief for it, however, is vanishing.

The chilling effect of a grant of immunity to hospitals in the absence of a hearing is clear: destroy the career of one physician, and hundreds or thousands of physicians will refrain from speaking out or competing against the perpetrators. The result is a crisis of national significance.

II. THE PETITION SHOULD BE GRANTED TO CURB THE LEGAL ABUSES ARISING FROM SHAM PEER REVIEW.

The overly broad immunity for bad faith allegations in peer review has resulted in legal abuses, and repetition by courts of contrivances as though they were factual. Often the allegations are even designed, with the help of the hospital bar, to have a superficial sensationalism in order to shock the layman. Peer review is becoming tabloid-like, with the science of medicine being replaced by what might shock a judge or newspaper reader when the mistakes are actually harmless or not even the physician's responsibility, and hospitals have an incentive in ruining good physicians who might compete. A grant of the Petition is necessary to curb the deceitful allegations and limit their repetition in court decisions. Obvious logical flaws and transparent sensationalism (for the layman) should no longer be tolerated in proceedings under HCQIA.

The leading medical expert in this field recently published an expose of the pattern of deception by hospitals to exploit the especially "unconventional standard" of immunity adopted by the court below. "The tactics used by hospitals and others in conducting a sham peer review are remarkably similar throughout the country." Lawrence Huntoon, M.D., Ph.D., "Tactics Characteristic of Sham Peer Review," *Journal of American Physicians and Surgeons* 64

(Fall 2009).[10] Dr. Huntoon emphasized about a dozen deceptive tricks played by hospitals, and several of these familiar deceits made it into the decision below. The decision below should be reversed on this ground alone.

For example, the court below disparaged Petitioner Wahi by saying he is "not a first-time offender." 562 F.3d at 613 (Pet. 29a). But Petitioner Wahi was exonerated every time he was falsely accused of something. The CAMC exonerated him in its own investigation, and the West Virginia medical board exonerated him three different times when it was prompted to investigate him. The fact that the hospital repeatedly asserted baseless, trumped-up charges is not an indictment of the accused, but of the accuser. It is evidence of improper use of peer review rather than improper practice of medicine. For the court below to use the fact of repeated review of a physician – while omitting that he was exonerated – is an illustration of how misguided its standard is.

Another example of a deceptive argument made by hospitals and which has superficial appeal – but which is logically nonsensical – is described by Dr. Huntoon as the "Numerator-Without-Denominator Tactic":

> Although the numerator-without-denominator tactic can be used against any physician, it is most commonly used against surgeons. Hospitals that

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[10] http://www.jpands.org/vol14no3/huntoon.pdf (viewed 11/6/09) (Neither AAPS nor its counsel has any control over the content of this journal; Dr. Huntoon has served as an expert in sham peer review cases, and has presented the material in this article as speeches accredited for Continuing Medical Education (CME) credits).

> use this tactic typically select cases that are specifically designed to highlight complications or negative outcomes. The selection of cases often falls outside the routine protocol used for selecting cases for review of physicians practicing at the hospital. The hospital then presents this select group of cases to peer reviewers as evidence that the targeted physician is a bad doctor or provides unsafe care.

Id. at 64. The defect of this approach – exploited by the hospital bar – is that statistically insignificant mistakes in a physician's record are meaningless for evaluating his record. Dr. Huntoon explained this further:

> Hospitals that use this tactic specifically omit the denominator (how many cases of that type the physician has performed over a period of time), thus eliminating the possibility of calculating a complication rate that could be used to make a fair comparison with statistics of other colleagues, or statistics published in medical literature. Virtually all surgeons, of course, experience complications, and the only surgeons who have zero complications are those who do not perform surgery, or who do not report their complications.

Id. at 65.

This fallacious approach of sham peer review was embraced below. The lower court adopted and applied a standard that encourages dismissal of cases no matter how small the "numerator" is and no matter how large the omitted "denominator" is in the hospital allegation. Respondent CAMC could not even find an adverse outcome to use against the cardio-thoracic surgeon Petitioner Wahi, so instead it relied on non-substantive allegations like "Failure to

obtain a proctor when required to do so." 562 F.3d at 611 (Pet. at 25a). Where is the "denominator" for that apparently inconsequential infraction? On this meager basis a surgeon's career can be destroyed? There is no indication of how often this occurred or what its significance, if any, was. In adopting a standard that allows discipline for this, the court's precedent violates the maxim of *de minimis non curat lex* (the law does not concern itself with trifles). Yet such specious accusations against good physicians and surgeons are encouraged by the standard adopted below.

No court would take seriously an allegation that an attorney was incompetent based on a statistic that he lost a certain number of cases without first asking what the denominator is: how many cases did he handle overall, and how difficult were those cases? But in a precedent cited favorably below, the Fifth Circuit took that defective approach in affirming reputation-ending discipline of a physician. *See Poliner v. Tex. Health Sys.*, 537 F.3d 368 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 1002 (2009).

In *Poliner*, the Fifth Circuit held in favor of a hospital despite proof of its bad faith in disciplining an innovative cardiologist. That court used several statistically insignificant examples dredged up by the hospital: a harmless rash, an unpreventable death, inadequate hospital diagnostic equipment, and nursing staff errors. The five cases at the heart of that decision were plainly contrived, as most consisted of patients who performed well, and included inevitable complications (like a rash) that were no fault of the targeted physician. *Id.* at 371-72. But as in other sham peer review cases, the hospital bar prefers examples designed to inflame an unjustified shock in a

layman (especially a court), rather than a bona fide medical deficiency. Operating on the correct artery but missing a second clogged one (due to equipment failure) was a medically harmless and statistically insignificant allegation against Dr. Poliner, but a claim having an exaggerated effect on a layman. *Id.* at 371 n.9 (repeating the allegation of a missed artery while holding that "for our purposes, it does not matter" whether the artery allegation was meaningful). These types of titillating but medically insignificant allegations now dominate peer review cases in judicial proceedings.

Another page from the hospital playbook for destroying a physician-competitor is to smear him as somehow being "disruptive". Huntoon, "Tactics Characteristic of Sham Peer Revew," *Journal of American Physicians and Surgeons, supra,* at 65. The decision below accepted that allegation at face value also: there were "[m]ultiple incident reports surrounding bizarre professional behavior and inappropriate personal behavior among nursing staff." 562 F.3d at 611 (Pet. at 25a). Nurses are employees of a hospital, and it is commonplace now for hospital administrators to arrange for these "incident reports" when they want to target a potential competitor for retaliation. This implausible accusation of "bizarre" and "inappropriate" behavior looks more like headline puffing found in the *National Enquirer* than an earnest evaluation of a surgeon's abilities and record. The hospital bar encourages accusations that shock a court (and newspapers), despite a lack of medical significance. CAMC's baseless assertion of "bizarre" conduct with nurses illustrates its bad faith in trying to frame a good physician. Yet the standard adopted below

encourages courts to accept these meritless and far-fetched charges at face value.

The Petition should be granted to curb the pattern of legal maneuvering and artful alleging with respect to what should be an honest medical evaluation of a professional's record of performance. Lower courts now repeat superficial accusations made by the hospital bar as though they have medical significance, when they do not. If the CAMC's specious allegations here demonstrate anything at all, they illustrate how strikingly clean Petitioner Wahi's record has been in the high-risk field of cardio-thoracic surgery.

The standard adopted below by the Fourth Circuit to shield accountability for sham peer review leads to an inappropriate grant of immunity to hospitals for contrived, insignificant accusations against physicians. The citation of trivial issues that are common to every busy professional are all-too-often accepted by lower courts as proof that the hospital was justified, and the decision below encourages this.

Distorted, shock-provoking assertions by hospitals in peer review have become commonplace. There is a thriving hospital bar that perfects the art of making a good physician look bad to the uninformed. The leading law firm for hospitals, Horty & Springer, actually conducts special seminars at luxurious resorts for hospital administrators, to teach them how to use sham peer review as a way of "[d]ealing with economic competition from medical staff members."[11] The sham peer review of Petitioner Wahi is right out of this playbook.

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[11] http://www.allianceforpatientsafety.org/hs2.pdf (viewed 11/6/09)

Physicians reasonably expect judicial review to be as logical as medicine and science are. But the lower court's expansive and erroneous implementation of the especially "unconventional standard" for immunity encourages more bad faith accusations, which then spill into judicial decisions. The Petition should be granted to curb these legal distortions.

III. HCQIA Immunity Does Not Extend to a Summary Suspension Taken Without Imminent Danger, Notice, or a Prior Hearing, and the Decision Below Thereby Interferes with Federalism.

The court below erred in conferring HCQIA immunity on a summary suspension taken without imminent danger, without proper notice, and without providing a prior (or even a subsequent) hearing to Petitioner. The adoption below of such sweeping immunity interferes with well-settled principles of federalism.

HCQIA expressly requires adequate notice and hearing procedures:

> "For purposes of the protection set forth in section 411(a), a professional review action must be taken – ... after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances."

42 U.S.C. § 11112(a) & (a)(3). CAMC concedes that there was no imminent danger to justify the summary suspension, that no prior notice was provided to Petitioner Wahi, and that a hearing was never held.

See Petition at 25; *Wahi v. Charleston Area Med. Center,* 453 F. Supp. 2d 942, 947 (S.D. W.Va. 2006), *aff'd*, 562 F.3d 599 (4th Cir. 2009).

This Court has noted in various contexts how notice and a hearing are essential parts of basic due process, and Congress cannot be presumed to allow immunity to attach in an absence of those essential safeguards. Justice Brennan observed in the securities context, for example, that even a short suspension "without notice or hearing so obviously violates fundamentals of due process and fair play that no reasonable individual could suppose that Congress intended to authorize such a thing." *SEC v. Sloan*, 436 U.S. 103, 123-24 (1978) (Brennan, J., concurring). "The fundamental requisite of due process of law is the opportunity to be heard." *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970) (quoting *Grannis* v. *Ordean*, 234 U.S. 385, 394 (1914)). In emphasizing the importance of adequate advance notice, the Court has stressed that "[t]he hearing must be 'at a meaningful time and in a meaningful manner.'" *Id.* (quoting *Armstrong* v. *Manzo*, 380 U.S. 545, 552 (1965)).

Nothing in HCQIA authorizes immunity for a summary suspension taken without imminent danger, notice and a hearing. In its Preamble, HCQIA limits its purpose to immunize against "[t]he threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, [which] ***unreasonably discourages physicians from participating in effective professional peer review***." 42 U.S.C. § 11101(4). Notice and a hearing are fundamental aspects of due process under both West Virginia and federal law. *See, e.g., Abshire v. Cline*, 193 W. Va. 180, 183, 455 S.E.2d 549, 552

(1995) (emphasizing that a hearing is a "fundamental right to due process").

Without a clear statutory mandate, Congress should not be presumed to have preempted due process protections, particularly in the traditionally local domain of medical practice. Where, as here, the dispute concerns "the usual constitutional balance between the states and the federal government," then statutory construction requires that Congress "must make **unmistakably clear** its intention to do so in the statute's language." *Premiere Network Servs. v. SBC Comm.*, 440 F.3d 683, 690 n.8 (5th Cir. 2006) (citing *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 65 (1989) and *Gonzales v. Oregon*, 546 U.S. 243 (2006), emphasis added). Congress did not make it "unmistakably clear" in HCQIA that it preempts traditional state-law rights to notice and a hearing. Nothing supports such a massive expansion in federal power over the medical profession. Where "Congress did not have this far-reaching intent to alter the federal-state balance and the congressional role in maintaining it," state law must remain applicable. *Gonzales v. Oregon*, 546 U.S. at 275.

The Supreme Court has emphasized that "where an otherwise acceptable construction of a statute would raise serious constitutional problems, [courts shall] construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress." *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988). The expansion by the decision below in the scope of HCQIA immunity causes a constitutional problem: it would lead to massive disruption of state law with respect to hospital administration.

This disruption would adversely affect all patients. Medical care is essential to nearly every American, and is the source of numerous controversial local issues from abortion to end-of-life care to so-called medical use of marijuana. Wholesale federal preemption of state law under an expanded HCQIA immunity with respect to hospital administration would violate well-established principles of federalism. As Justice Kennedy has observed:

> [F]ederalism was the unique contribution of the Framers to political science and political theory. Though on the surface the idea may seem counterintuitive, it was the insight of the Framers that freedom was enhanced by the creation of two governments, not one.

United States v. Lopez, 514 U.S. 549, 576 (1995) (Kennedy, J., concurring) (citing H. Friendly, "Federalism: A Foreword," 86 Yale L. J. 1019 (1977) and G. Wood, *The Creation of the American Republic, 1776-1787*, pp. 524-532, 564 (1969)).

Nationwide, hospitals seek to extend HCQIA immunity beyond sensible limits in a manner that would lead to federal control over all of medicine. This is contrary to precedent and congressional action. This Court has emphasized that "[o]bviously, direct control of medical practice in the States is beyond the power of the Federal Government." *Linder v. United States*, 268 U.S. 5, 18 (1925). At no time has Congress attempted to alter state jurisdiction over medicine, despite the urgings of hospitals. "Unless Congress conveys its purpose clearly, it will not be deemed to have significantly changed the federal-state balance." *United States v. Bass*, 404 U.S. 336,

349 (1971). Congress never authorized such a complete disregard of state law for medical practice, an area in which "[s]tates lay claim by right of history and expertise." *Gonzales v. Raich*, 545 U.S. 1, 48 (2005) (O'Connor, J., dissenting) (quoting *Lopez,* 514 U.S. at 583 (Kennedy, J., concurring)).

The Supreme Court of Nevada has already concluded that there are meaningful limits on the scope of immunity under HCQIA. This has benefited Nevadan patients and physicians alike. *See Clark v. Columbia/HCA Info. Servs.,* 117 Nev. 468, 25 P.3d 215 (Sup. Ct. Nev. 2001). There the court denied HCQIA immunity to the hospital (HCA) for revoking a physician's privileges based upon the pretext of disruptive behavior by the physician. In reversing a grant of summary judgment to the hospital by the court below, the court held that "the board is not entitled to immunity as a matter of law." 117 Nev. at 480, 25 P.3d at 223. That court found that the real reason for the sham peer review against the physician was his filing of reports critical of the hospital.

Similarly, a state court in Connecticut has rejected the insatiable demand of hospitals for complete federal immunity. In *Harris v. Bradley Mem. Hosp. & Health Ctr.*, 2005 Conn. Super. LEXIS 1401 (Conn. Super. Ct. May 19, 2005), the court held that HCQIA does not immunize a hospital against all claims for damages because not all summary suspensions qualify as peer review under HCQIA. That court decided:

> After a review of the case law and the evidence, presented by the plaintiff, the court concludes that the plaintiff engaged in more than one professional review action and that the plaintiff has demonstrated the existence of a genuine issue of materi-

al fact concerning whether one of those actions satisfied the statutory requirements for immunity.

Id. at *15 · *16.

Neither the plain meaning of HCQIA nor well-established principles of federalism support the decision below, which applied immunity to a summary suspension without imminent danger, notice to the physician, or a subsequent hearing.

CONCLUSION

This Court should grant the Petition for Writ of Certiorari.

Respectfully submitted,

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IN THE

Supreme Court of the United States

RAKESH WAHI, M.D.,
Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF OF *AMICUS CURIAE* SEMMELWEIS SOCIETY INTERNATIONAL, INC.

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COMES NOW, SEMMELWEIS SOCIETY INTERNATIONAL, INC. by and through counsel and files this its Motion to File *Amicus Curiae* Brief with the consent of the Petitioners to this matter.

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BRIEF OF *AMICUS CURIAE* SEMMELWEIS SOCIETY INTERNATIONAL, INC.

INTEREST OF *AMICUS CURIAE* [1]

Amicus SEMMELWEIS SOCIETY INTERNATIONAL, INC. (SSI) is a non-profit organization that protects physicians, nurses, and healthcare professionals, so they can ethically do their jobs to provide better, safer and less costly medical services.

[1] Pursuant to its Rule 37.6, counsel for *amicus curiae* authored this brief, and no counsel for a party authored this brief in whole or in part; nor did any person or entity, other than *amicus*, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

SSI's MISSION: to ensure healthcare professionals' rights to provide, or advocate for, quality and cost-effective—optimum—medical services. SSI promotes optimum medical diagnoses and treatment for every patient, care that is continuously improving and safer; more and more efficient and effective as knowledge and techniques improve, yet less costly. SSI advocates for the rights of healthcare professionals and staff to be free to provide, or advocate for, optimal and safer patient care without suffering retaliation from administrators or colleagues. Run-of-the-mill doctors are threatened by physicians like Dr. Wahi, *e.g.*, because they provide medical services that are better, safer, and routinely less costly than average physicians. Hospital managers don't like physicians like Dr. Wahi because they "Do it right the first time," with minimal use of expensive testing machines and fewer medical errors and infections that hospitals get paid to treat. Optimal care physicians also tend to "cream" high-reimbursement surgeries and other high-end medical services, putting ordinary physicians and the hospitals where they practice at a competitive disadvantage.

SSI UNDERSTANDS why hospitals and physicians' groups try to get control of the medical services within their geographically-drawn patient service areas. Besides setting a "bad example," Dr. Wahi and other providers of optimum diagnostics and patient care are unwanted competitors because their charges and results tend to lower reimbursement rates and revenues for similar medical services in their practice demographic. By protecting healthcare professionals who provide optimal care, SSI's work for quality-care physicians cuts medical costs for patients, insurers, and all government-paid programs including MEDICARE and MEDICAID.

SSI's VISION: physicians and medical staff fully protected by the law, empowered so they feel, and in fact are, free to provide optimum patient care. The more patients receive optimal medical services, the lower the percentage of Gross National Product (GNP) consumed by medical spending.

BACKGROUND

By participating in this action in support of a high-quality-care physician, SSI encourages all healthcare professionals to work conscientiously for patients' welfare and safety. They know there is an organization that supports physicians' advocating for and delivering appropriate/optimum patient treatments, even when pressured by hospitals and physician-colleagues to delay diagnoses and to under, or over-treat, patients. When doctors, nurses, and technicians are effectively shielded from retaliation, medical professionals (most of whom are conscientious and want to practice optimal, cost-effective medicine that helps, not hurts the patient) can follow their ethical duties and put the patient—not revenues and profits—first.

Unfortunately for our Nation's health, far worse than it should be considering our vast spending on healthcare[2] and by now a dangerously escalating percentage of GNP[3], the Fourth Circuit's misreading of

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[2] Current annual healthcare spending is estimated between $2.3 and $ 2.6 trillion. But as a group, Americans are not getting good value for their medical dollars. From SSI's experience, a major cause of the high cost for on-average low value medical care is that physicians are fearful of practicing or promoting, optimum, cost-effective medicine, for the reasons explained in this *amicus* brief.

[3] Generally agreed percentage is 16-18 % of GNP and growing at a dangerous rate, so fast some experts forecast unsustainable

the Health Care Quality Improvement Act (42 U.S.C. § 11111 *et seq*. (1986) (HCQIA)) in *Wahi*, gives hospital managers and the physicians who cooperate with management, essentially unaccountable powers. Using the *Wahi* decision, revenue-hungry hospital managers and the too-often mediocre-care physicians who work in league with them, now have legal immunity to drive out of their self-drawn demographic monopoly service areas, physicians like Dr. Wahi whose quality and lower costs threaten their revenue streams. Medical service revenues and reimbursements for conventional medicine as typically practiced include 25 to 40 percent (25-40 %) unnecessary, excessive and expensive diagnostics and treatments that too-often end up harming the patient (*see, generally*, Shannon Brownlee, Overtreated—Why Too Much Medicine Is Making Us Sicker and Poorer (2007)).

This Court ruled in *Pegram v. Herdrich*, 530 U.S. 211, 219-220 (2000), that physicians' codes of ethics require them to ignore strong financial pressures to undertreat patients. Even when severely disincentivized to provide appropriate care, as was defendant-physician Lori Pegram M.D., a unanimous Court ruled that physicians' professional ethical imperatives will keep them providing "covered [medical] services with a reasonable degree of skill and judgment in the patient's interest" (*Id*).

Pegram approved crude financial incentives which the Court assumed influenced treating physician Lori Pegram to delay diagnostic tests for plaintiff-patient Cynthia Herdrich; despite evidence the tests were

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federal deficits brought about principally by government spending for its share of healthcare.

immediately medically necessary.[4] *Wahi* involves a physician who practiced high-quality medicine but whose termination is supported by the District Court and the Fourth Circuit under a reading of HCQIA that ignores both the language of the statute and plainly expressed Congressional intent.

The Fourth Circuit's *Wahi* decision takes federal courts' reliance on physicians' ethical obligations to an unreal extreme: first making physicians silent slaves to those in control of credentialing and peer review, yet still expecting them to be independent professionals who will advocate for and practice quality patient care. The reality is that *Wahi* stripped away the few remaining HCQIA procedures physicians still had to protect themselves—and their patients who are the immediate sufferers from too-many tests and procedures and generally bad medicine—against revenue-hungry hospital administrators and mediocre-care colleagues who practice quantity-care, not quality-care.

Two key HCQIA protections for physicians the Fourth Circuit eliminated in *Wahi* are the need for a finding of "imminent danger" to patients prior to summarily suspending a physician, (42 U.S.C. § 11112 (c) (2)) and the right to an objective hearing on the charges against them (42 U.S.C. § 11112 (a)

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[4] Plaintiff-patient Cynthia Herdrich recovered $35,000 in a state malpractice action against treating physician Lori Pegram M.D. The issue before the Supreme Court relevant to this *Amicus* was the legality of the incentive arrangement that presumably caused Dr. Pegram to delay Herdrich's testing. Pegram ordered an 8-day delay before Herdrich could be tested, a delay that conformed to her contract and enabled Pegram to qualify for incentive payments. Herdrich's appendix burst before she could be tested.

and (b)). CAMC officials, their experts and the other physicians who cooperated in the campaign to terminate Dr. Wahi, must have known from the positive results Dr. Wahi achieved with his patients that he was a quality-care physician. Even though Dr. Wahi credibly alleged that economic competition drove the process inside CAMC that terminated his hospital privileges and made him unemployable as a surgeon,[5] the Fourth Circuit denied him any relief.[6]

How can physicians who know the result in *Wahi* be expected to provide appropriate/optimum care for their patients when they know that practicing efficient, effective, safe medicine that generates far less gross revenue for hospitals and medical practices can doom their careers? How can doctors be expected to ignore the intense professional and financial pres-

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[5] As noted in both opinions and discussed by Petitioner, Dr. Wahi's summary suspension and other adverse actions were reported to the National Practitioner Data Bank, reports required of CAMC by law, making a permanent record which destroyed Dr. Wahi's career as a surgeon. (*See* practitioner Charles Artz's observations on the effects of Data Bank entries (Appendix G, 35a).

[6] Yann Van Geertruyden, in The Fox Guarding The Henhouse: How The Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review In The Medical Community, 18 J. Contemp. Health Law 239 (2001), told Alan Ullberg how his father, a physician with a thriving independent medical practice, suffered bad faith peer review when he refused to join a local medical group. That was a family experience which informed the son of bad faith peer review to enforce economic demands on a physician who holds out for his independence. From living through his father's experience, the author could write credibly of the constant fear of sham peer review as the "problem in the medical profession which is known by many, but spoken of by few."

sures to conform to the present high-expense, over-testing and overtreating practice of medicine?[7]

The Wahi decision allows unexamined expert opinions solicited and paid for by CAMC—opinions which exonerated Dr. Wahi—to immunize CAMC's officials and those physicians cooperating with CAMC. Erroneously, the Fourth Circuit held that favorable reports by CAMC's experts and staff physicians as to the risks to patient care and safety that Dr. Wahi was alleged to present, could be used to meet HCQIA's "fair under the circumstances" standard as discussed in both opinions.

Close examination of the facts including the back-and-forth communications while the parties unsuc-

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[7] *See, e.g.*, Professor Myers' recounting (text, below) that even Mayo Clinic hospitals enforce revenue production targets on staff physicians.

> SSI notes that practicing defensive medicine to avoid malpractice liability also contributes to the present patient treatment climate of "the more tests and procedures the better." Without getting into whether this particular "chicken" (overtreatment) or this particular "egg" (defensive medicine) came first" we suggest that as over-utilization of diagnostic and treatment resources spiraled upward, "over-utilization" becomes the medical standard for judging if there was "malpractice." It will take some time to wind this combination over-treatment/malpractice spiral back down to the ideal level of "optimum medical diagnostics and treatments." In the interim while conscientious healthcare providers are trying in good faith to cut back on excessive diagnostics and over-treatments, they may need special legal protections against malpractice liability when, *e.g.*, they refuse to test and treat a patient when there are no medical reasons to test or treat.
>
> Of course, high-expense medicine practiced to obtain the most revenue per patient is, for obvious reasons, usually confined to the well insured or wealthy.

cessfully negotiated the dates and details for a hearing on the charges against Dr. Wahi, reveals that CAMC artfully avoided holding an objective hearing by never providing Dr. Wahi or his attorney sufficient information so they could know how much there would be to answer for. Not knowing who the witnesses would be or what number or complexity of charges the witnesses might present, no hearing date could be set. Yet by misinterpreting HCQIA's due process and hearing rights CAMC was able to construct an argument adopted by both the trial and appellate courts that blamed Dr. Wahi for not having a hearing.

Because Dr. Wahi never received notice before his summary suspension, and there never was an objective hearing on the allegations and charges, Dr. Wahi was denied effective opportunities to challenge the accusations or his accusers.

QUESTIONS PRESENTED BY THE PETITIONER

1. The Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152, provides a hospital immunity from monetary damages for disciplining a doctor "*after*" providing "adequate notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). By contrast, the Act allows disciplining "immediately"—that is, *before* notice and a hearing or other "fair" procedures—only where "failure to take such an action may result in an imminent danger to the health of any individual." § 11112(c).

Did the court below err in holding, in conflict with four other circuits, that a hospital can obtain immunity for disciplining a doctor immediately—before notice and a hearing—where the

hospital concedes that it did not find or rely upon the possibility of imminent danger?

2. Under the Act, may an immunity determination be made by a jury, as the First and Tenth Circuits hold, or is a jury forbidden from making such a determination, as the Eleventh Circuit and Colorado Supreme Court hold—and as the Fourth Circuit effectively held here?

REASONS FOR GRANTING THE PETITION FOR CERTIORARI

Besides stopping physicians from providing or monitoring optimum patient care and safety, *Wahi* has silenced those best situated to report healthcare overtreatment and outright MEDICARE fraud. Physicians are on-site with their patients; working with them hands-on and monitoring their condition; able to revise diagnoses or treatment procedures; and to complain or make suggestions in real-time including how the hospital is billing for a patient's care. But the *Wahi* decision effectively freezes every physician's critical voice. Doctors rarely talk about it, but they all know what can happen if they question whether the patient should be subjected to multiple tests or procedures; or if they report billings for unnecessary treatment or other MEDICARE fraud (*see* the story of Patrick Campbell, Appendix H).

Michael J. Myers, healthlaw and healthcare business administration professor, spent 17 years as counsel and CEO of nonprofit hospitals before returning to university. He understands the organizational and financial forces driving healthcare. In March 2008, Myers gave an example from a hospital operated by the Mayo Clinic.

> [T]he fundamental corporate restructuring the United States healthcare system has undergone, since the enactment of HCQIA . . . [has] implications for physicians who now overwhelmingly are "employees" of large, integrated, and economically and politically influential healthcare systems. We should dwell upon the influence of such corporate integration upon physician behavior and increased risk for a physician who does not adhere to the clinical and financial forces that drive system profitability. Last semester I had a former Mayo pediatric oncologist confirm how corporatization of Mayo has affected clinical judgment and [physician] autonomy. The employed physician who suggests that certain diagnostic and surgical procedures may be unnecessary and not in the best interests of patient care may be frustrating utilization targets and undermining the "production" incentives found in the contracts of employed physicians. The CEO/CFO and Medical Director will likely be offended with such conduct, as will fellow physicians who stand to profit from increased "clinical production."[8]

Wahi heightens what Professor Myers calls the ". . . increased risk for a physician who does not adhere to the clinical and financial forces that drive system profitability." Since *Wahi*, any evidence hospital managers can put in the record that indicates a targeted physician may have provided unauthorized or substandard patient care, will support the physician's termination even if there is no objective hearing or equivalent proceeding to fairly determine the medical

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[8] E-mail to Alan Ullberg from Professor Myers: March 25, 2008, in Ullberg's files.

truth and validity of the allegations of the targeted physician's unsafe or unauthorized actions.[9]

HCQIA jurisprudence allows appellate courts to cherry-pick evidence from the record to make their one-sided findings of "objective reasonableness." The Fourth Circuit's affirming CAMC's bad faith peer-review actions plays right into the hands of the managers of hospitals, profit and nonprofit, increasingly driven by the bottom line.[10]

Doctors are human. They make mistakes just like everyone who drives a car. It is well known among police officers that closely observing any driver will reveal a continuous series of inconsequential technical infractions. A trained police officer can appear in court and present his observations as "key evidence" to support a judgment of "safety risk." A

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[9] "Peer review wasn't intended as a means to oust qualified physicians to the benefit of their more economically successful competitors, says James Lewis Griffith, Sr., a malpractice attorney in Philadelphia. 'Too often, however, the golden rule applies: He who has the gold makes the rules.'" (quoted by Gail Garfinkel Weiss, Is Peer Review Worth Saving? Medical Economics, Feb. 18, 2005 (*see* medicaleconomics.modernmedicine.com/memag/article/article/Detail.jsp?id=147405)

[10] Michael Myers, 51 S.Dak.L.Rev. 465, 466 (2006), commenting how nonprofit regional hospitals "typically enjoy oligopolistic market power in a region . . . [so] physicians, executives, board members, and their aligned business interests are able to place private interests ahead of their presumed public interest without significant risk of detection or penalty. These modern, multi-billion-dollar health systems earn revenues . . . to accommodate their collective interests, attracting an array of entrepreneurial constituents because, to quote bank robber Willie Sutton, that is 'where the money is.' . . . These . . . are bottomless, in part, because of the conflicts between the stated missions of hospital systems and their actual performance in the market."

reviewing court will likely affirm the trial court's judgment based on that finding. Under this scenario, any driver can be adjudicated "unsafe," just like any physician can be adjudicated a patient-safety risk.[11]

The Fourth Circuit's extreme standard for HCQIA judicial review allows an appellate court of lay judges, not trained in medicine, to make medical judgments. Judges can affirm and immunize medically unchallenged and incorrect physician credentialing actions driven, as here, by CAMC's economic interests which have destroyed an excellent surgeon's career. Handpicked "evidence" from the record sustains peer-reviewers' alleged economically motivated actions as "objectively reasonable." The kangaroo court peer-review affirmed in nearly all HCQIA cases is the opposite of the standard for hospital accreditation:

> . . . [O]bjective, evidence-based decisions regarding appointment to the membership on the medical staff, and recommendations to grant or deny initial and renewed privileges."[12]

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[11] Shannon Brownlee, Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer (2007), quoting a surgeon that "good doctors make mistakes too. . . . [E]very physician is destined to make at least one horrible mistake in the course of a career—and most will carry the memory and shame of it for the rest of their lives." (p. 53).

[12] In a July 09, 2008 bulletin, *Applicable Joint Commission [accreditation] Standards (see Appendix F)* JCAHO describes generally the Medical Staff Standard for ". . . maintenance of a credible process to determine competency . . . " That is an objective, professional-medical inquiry. The peer-review actions reviewed and affirmed by lay judges such as in the 4th Circuit bear no resemblance to a proper professional inquiry aimed at getting at the medical truth of the matter.

Courts ought to look to these professional canons for the due process and fairness standards that should be applied in HCQIA cases, not ignore both the language and intent of the statute which was to provide fundamental fairness to peer reviewed physicians.

Officers and members of SSI attest that "*The Wahi Principle: "Any evidence of substandard medicine, no matter how contrived or flimsy, will support bad faith peer review actions that are so difficult to challenge that as a practical matter there is no accountability*," has chilled the medical community.

There is even less chance than before *Wahi* that those few doctors who might have broken their silence to save a patient from death or serious injury[13] will take the ultimate risk of career and medical license to save a patient's life.[14]

SSI fully supports good faith peer review. Being human, physicians can become impaired, disruptive, or lose their medical skills. But *Wahi's* facts and holding create a classic Machiavelian tutorial: *"How*

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[13] SilenceKills.com (Appendix B) reports the results of a statistically-based survey funded by the American Association of Critical-Care Nurses. The purpose was to find out if the average physician or staff would speak up when they see medical errors happening or about to happen, in real time so the patient will not be harmed. Results were less than 10 % of physicians will speak out when they see medical errors "in progress," even life-threatening errors that could kill a patient immediately. The *White Coat of Silence* describes nurses' reluctance to report what they see, and some of the reasons for the lockdown of nurses' "free professional speech" in most hospitals. (Appendix A).

[14] *See* Charles I. Artz's paper, (Appendix G), noting how mandatory reports to a central data bank of the results of clinical privileging proceedings can quickly and permanently ruin a good doctor.

to Destroy A High-Quality Physician Who Is In Your Way!" If the Wahi principles are allowed to stand, *any* excellent *physician can* be labeled "unsafe" and a "potential threat to patient safety" because all physicians have been effectively stripped of HCQIA's statutory fairness and due process rights.

While the stated objective of peer-review is to protect patients by improving the pool of practicing physicians ("Good doctors weeding out bad doctors"—the well-intentioned but naïve goal of HCQIA), trending federal court decisions culminating in *Wahi* immunize illegitimate peer review actions. The bad doctors are both empowered and protected by HCQIA immunity. Because bad doctors tend to bring in more money than good doctors,[15] hospitals are financially pressed to encourage their bad doctors to drive out their good doctors. *Wahi* perfectly supports this perverse (and very expensive-to-our-GNP) scenario which has turned HCQIA on its head. Federal courts' interpretation of HCQIA allows bad doctors to stay in the healthcare system and keep medical spending artificially high, persecuting their competition while

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[15] Brownlee, *supra*, discusses throughout examples how good programs for patient wellness, treatment and safety often fail because cost-effective treatment, by definition, is not a big money-maker. On the other hand, bad doctors create complicating conditions so hospitals are able to add diagnoses to the patient's chart and be paid for additional levels of care and treatment (*see e.g.*, Brownlee at Appendix H, 49a, 54a, 65a-70a)

wrapped in the cloak of HCQIA's immunity.[16] The good doctors who practice high-quality, cost-effective medicine like Dr. Wahi are driven out of hospitals and clinics, too-frequently to mental breakdowns and suicide. A system that encourages the destruction of good doctors is a genuine national disaster. Yet *Wahi* immunizes and consequently empowers the quantity-care forces in our healthcare system that are threatened by good, optimal care physicians and their high quality and far cheaper doctoring.

The principle in *Wahi* of gravest concern to SSI is the near-absolute deference to peer-reviewers regardless of their motives—and regardless of the outcome of their reports. Peer-reviewers and the hospital managers who control the peer-review process can professionally discredit any doctor for trumped up reasons; yet such actions are affirmed because any flimsy allegation of substandard medicine meets the *Wahi* test, even if the physician, as here, is ultimately exonerated. Hospital managers can credibly threaten otherwise-good physicians with virtually unchallengeable peer-review actions. The doctors we need the most at this time of crisis in our

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[16] Gail Garfinkel Weiss, in her Medical Economics article quoted in fn. 9, recounted the experiences of Steven I. Kern, a New Jersey plaintiff's attorney, a veteran of peer review actions against physician-clients. Mr. Kern told Ms. Weiss:

> In the 30 years that I've been a health law attorney . . . I've never seen anyone who admits a lot of patients and is well-liked have a problem with the hospital disciplinary mechanism. On the other hand, if you're competing with such a doctor, especially if you're new to the hospital or on the wrong side of hospital politics, you're a potential target. (p. 2).

Nation's medical care system are forced to act like sheep instead of watchdogs.[17]

Consequences from *Wahi* will continue the high rate of mostly preventable hospital and clinic-caused patient deaths and medical-error injuries. The 1999 study by the Institute of Medicine found almost

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[17] Professor Myers commented on the disastrous national fallout from *Wahi, with the "dog-pack" analogy he uses when he teaches this problem in his healthcare business management and healthcare law classes:*

> ***Physician Dog-Pack Behavior:***
> ***Federal Court Culpability***
>
> The Charleston Area Medical Center, structurally and behaviorally, is a *private club.* Circuit court splits and erroneous interpretations of HCQIA allow it to function as such, immune from accountability, free to eliminate competition, capable of assembling market power without meaningful federal anti-trust enforcement, and perpetuating the mythical underpinnings of nonprofit healthcare. The Fourth Circuit ruling not only ratifies the unwarranted destruction of an excellent physician's professional life and provides a rule book for destroying thousands more physicians of the kind this country desperately needs right now, it sanctions behavior that contributes to the concentration of market power underlying this Nation's quality and fiscal healthcare crises. Besides offering an opportunity for the federal courts to examine "physician dog-pack behavior" and how it is used when one of its members attempts to leave and compete with the pack, there are the larger issues of how nonprofit hospitals are essentially exempted from anti-trust principles. As illustrated by CAMC's unworthy actions in this case, our local nonprofit hospitals too often have abandoned their missions of service, becoming bastions of money and power corruptly capitalized by Government and insurers' dollars that are used to control healthcare services for the benefit of the members of each local private club like those who appear to control CAMC. (Email from Professor Myers in Ullberg's files).

100,000 patient deaths per year caused by medical errors, and updates indicate that number stays about the same year-by-year.[18] Another estimated 100,000 die from hospital-acquired infections.[19] Bad medicine also costs all payers including the taxpayers, hundreds of billions more than the good medicine practiced by physicians like Dr. Wahi.

Current healthcare spending now is about 17 % of Gross National Product and rapidly rising. Physi-

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[18] L. L. Leape and D. M. Berwick, "Five Years After 'To Err Is Human:' What Have We Learned?" Journal of the American Medical Association, May 18, 2005, 2384-90 ["[T]he groundwork for improving safety has been laid in these past five years but progress is frustratingly show"].

[19] *See* Wall Street Journal Health Blog, June 9, 2009, commenting on AMA proposed actions to reduce the 100,000 per year deaths from hospital-acquired infections. If 548 people died every day in airline crashes (100,000 from medical errors + 100,000 from hospital infections = 200,000 divided by 365 = 548) something would be done to stop the killing. Unfortunately, for our purposes the law has paralyzed those best positioned to reduce and eventually stop these deaths that are nearly all preventable. (Naida Grunden, The Pittsburgh Way to Effective Healthcare: Improving Patient Care Using Toyota-Based Methods (2008), They are the conscientious physicians, exemplified by Dr. Wahi's excellent record as a cardiac surgeon, who have the will and the medical knowledge and skills to practice optimum patient care.

The numbers on hospital acquired infections probably were derived from an article in 122 PUBLIC HEALTH REPORTS, March-April 2007, 160-167, authored by R. Monina Klevens, DDS, MPH and 6 colleagues, "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002." Klevens and her colleagues concluded: "Among the 1.7 million patients with an HAI [Hospital Acquired Infection] in 2002, there were 155,668 deaths, of which 98,987 were caused by or associated with the HAI." (122 PUBLIC HEALTH REPORTS 164)

cians, the most knowledgeable and perceptive onsite monitors of cost-benefit-balanced patient treatment plans oriented to economy, no longer can speak up and challenge excessive treatments and overbillings. Even when they know their hospital is committing massive MEDICARE fraud, they cannot afford to risk career and license just to save taxpayers a few hundred million dollars.[20]

Wahi severely and adversely impacts healthcare quality, safety and cost. This Court should grant the Petition and reverse.

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[20] The personal and professional consequences to Patrick Campbell, M.D., an unwelcome and unappreciated MEDICARE fraud reporter, are described in selected pages from *Overtreated*, Appendix H. His persistence saved many lives and millions of healthcare dollars, but the upheaval in his life was more than most people are willing to risk for a principle.

CONCLUSION

Amicus SSI respectfully prays that this Court grants Certiorari and correctly interprets HCQIA. Physicians then will be able to trust they have enforceable due process rights to sustain the independence and free speech protections they need to advocate for patients and provide optimum medical care, making healthcare better, safer, and cheaper. SSI prays for relief for physicians like Dr. Wahi who in fact are the key to solving both the quality and the cost problems with healthcare. Reversal by this Court is prayed, for all patients' health and financial savings; and further for our Nation's economy and the long-term prospects for financial solvency of the United States of America.

Respectfully submitted,

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APPENDIX

APPENDIX A

The "White Coat" of Silence

LET'S CONSIDER A SCENARIO, that may or may not be hypothetical—that will be for you to decide. In an unnamed hospital, a newly appointed Chief Nursing Officer (CNO) is hired as a change agent, or at least that is what she is told by the hospital's Chief Executive Officer (CEO) and several Vice Presidents. As a first order of business, the CNO begins to document problem areas at the hospital. The list includes a director of Nursing (DON) who prevaricates, especially when it comes to defining staffing needs; abandonment of duty by some nurses in the chain of command; a nurse who continues to make medication administration errors; the failure of the computerized charting system to perform as expected; and other problems of the same importance.

When verbal reports to a superior fall on deaf ears and generate responses such as "the DON is doing what she can," the CNO decides to write a detailed memo outlining the problems and her recommendations. A copy of the CNO's report then is given to the CEO and all department VP'S including the CNO's direct superior. One would expect that hospital administration would show appropriate concern for the severity of the documented deficiencies and plan for immediate corrective action. However, this is a management-impaired hospital and following the unspoken rule of the hospital of "killing the messenger," the CNO is sacrificed for failing to adhere to another unspoken rule of the hospital

By Geneviève M. Clavreul, RN, PhD.

Hospitals, like police departments and other institutions, have their own codes of silence to protect against human error—no malice, no ill intent, no nefarious plan—just plain old human error.

and nursing administration, which is "bring us no bad news."

For many, the above example will have the ring of truth, because this situation exists in their hospital today, or in the past. There will be others who say their hospital would never tolerate such a practice. But the above does put a spotlight on what I have come to call the "White Coat of Silence."

Hospitals, like police departments and other institutions, have their own codes of silence. This code was established to give a person some protection from the consequences of what is often just human error—no malice, no ill intent, no nefarious plan—just plain old human error. However, as in police work, there are times when the white coat of silence is extended to cover the mistakes of a person who is incompetent or unethical. When this happens, the healthcare community violates its trust with the public it serves and bad outcomes follow.

The cloak of privacy offered by quality improvement projects should not be confused with the white coat of silence. The shield of privacy is invoked to allow the hospital staff to freely and fully investigate a medical or nursing mishap or error. This shield is offered under the theory that privacy assurance will allow the nurse or doctor, without fear of retribution and accusation, to discuss the mistake that occurred. This does not mean that the nurse or doctor responsible is free from consequence if an event is deemed caused by negligence or poor care.

An effective quality improvement process leads to an environment where patient rights and care are placed at the forefront without relegating the nursing and medical staff to second-class status. The white coat, on the hand, places emphasis on protecting the nursing and medical staff first and encourages an environment where patient rights and care are not the core focus of the healthcare team.

The white coat flourishes in an environment where hospital administration and nursing management in particular, is viewed as hostile towards good nursing practice. This insidious code creeps into a hospital as a defense against what is viewed by employees as an administration that is unresponsive and often retaliatory.

Though society may reward the whistle blower for calling attention to malfeasance, safety issues, and, in the case of nursing, poor or negligent patient care--the reality is that the administration, and in some cases the nursing team itself, does not support the nurse who is a whistle blower. It is an unfortunate occurrence within nursing, and it doesn't have to be this way.

I was having lunch with a nurse whom I had known and worked with many years ago. Catching up on old times we chatted about the numerous experiences and frustrations our many years of nursing had brought us. She shared with me an experience she had one night many years ago at one of Los Angeles' finest hospitals.

She and five other nurses, a tech, and two doctors were preparing to move a patient into surgery. The need for surgery was immediate and urgent, and as they prepared the patient one of the doctors handed

her a pre-filled syringe and ordered that she administer it to the patient. Since she did not draw the medication and, therefore, did not know what was in the syringe she asked the doctor what the syringe contained. He refused to tell her, stating instead that without it the patient would suffer ill effects and that she had to administer it.

Of course she refused, and stated that the physician should administer it instead. He refused and then ordered one of the other nurses to do it. After much haranguing and brow beating one of the other nurses acquiesced and administered the injection of the mystery drug. Afterwards, she reported the occurrence to nursing service; each of the other five nurses confirmed her story and supported her complaint. But the tech and the mystery syringe doctor both developed amnesia. Shortly after the complaint, the six nurses began to find themselves pressured to find other employment–the white coat of silence strikes again.

A reasonable person might have thought that the doctor who insisted that the nurse administer an unidentified drug would have been the one to be made to suffer for his unprofessional and possibly dangerous actions, but of course, hospital management is not always known for reasonable behavior.

What happened to my friend and the other nurses is the byproduct of poor and weak management, not an uncommon occurrence in the hospital setting.

All too often a nurse who makes a complaint about another nurse or doctor is made to weigh in advance the possible repercussions to herself. Often the act of reporting their suspicions to the charge nurse or head nurse is enough to mark the nurse as a troublemaker

and thus, a potential victim of kill the messenger syndrome. Poor managers often feel threatened by the nurse who steps forward, especially if the nurse being reported is perceived by nursing management as a hard worker.

The weak manager often confuses the nurse who is willing to work any and all shifts, multiple days, fetch coffee, run errands, with being a nurse, when in reality this nurse is usually a sycophant who is undermining the esprit de corps. A consequence of the sycophant's behavior is that the manager often rewards them for being a teacher's pet while the very real concern of the whistle blower is ignored and the whistle blower is the one who is punished. It only takes one or two negative consequences before the nursing staff gets the message. Good nurses start updating their resume or, worse, stop caring.

Does the white coat have to rule nursing practice in our hospitals? Of course not! Most nurses abhor the thought of poor nursing care being hidden, yet feel totally helpless to do anything about it for fear of losing their job or, worse yet, their license.

The white coat thrives in two environments: where there is

Reporting suspicions to the charge nurse is often enough to get marked as a troublemaker and potential victim of the kill the messenger syndrome.

poor or weak nursing management that does not advocate for patients and nurses, and where nurses fail to support the whistle blower.

Changing this work environment is not impossible. When nurses work together to define and enforce the highest standards of nursing practice then nursing

management has little choice but to respond. They learn that nurses demand leaders to show backbone. Mediocre nurses quickly change their behavior or move on when they realize that their obsequious and sycophantic behavior is unrewarded. Floor nurses can have a dramatic effect on who the hospital administration appoints as the CNO, and ultimately on who the CNO appoints as DON, who the DON appoints a s Head Nurse, and so on.

THE WHITE COAT OF SILENCE IS NURSING'S DIRTY LITTLE SECRET. It can only thrive in an environment that is permissive and unresponsive. If you know that you are working in a hospital where the "white coat of silence" is the rule and not the exception, there are some steps you can take to protect your patients and yourself.

FIRST AND FOREMOST, always document. Although documenting can be time consuming, it is important to create a paper trail.

SECOND, become thoroughly familiar with your hospital's quality improvement protocol and employee discipline process.

THIRD, when reporting unsafe nursing practices, sentinal events, possible errors, and so on, always follow the chain of command and keep a copy of the documentation that you submitted.

FOURTH, if the situation worsens, or you begin getting the feeling that you are working around with a "target on your back," give serious consideration to looking for a position in another hospital.

It may seem extreme to change jobs when confronted with the white coat but it's not. If you are working in a hospital where the norm is to ignore real and valid

concerns about safe nursing practice and good patient care you cannot personally solve a system-wide problem. What you can do, however, is to provide the documentation that administration was informed, but that they chose to remain ignorant of the problems. Why? Because when the hospital suffers an event big enough—if it tolerates a white coat of silence, it eventually will—then it won't be able to hide its practices.

Then your documentation can be used to instigate change.

Genevieve M. Clavreul is a health care management consultant. She is an RN and has experience as a director of nursing and as a teacher of nursing management. She can be reached at: Solutions Outside the Box; PO Box 867, Pasadena, CA; gmc@solutionsoutsidethebox.net; 626-844-7812.

THIS ARTICLE IS ARCHIVED ON LINE.

http://www.solutionsoutsidethebox.net/documents/2005/White%20Coat%20of%20Silence.pdf

The 'White Coat' of Silence: Working Nurse Feb 21, 2005 pages: 11-15.

APPENDIX B

FOR IMMEDIATE RELEASE
January 26, 2005

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New Study Finds U.S. Hospitals Must Improve Workplace Communication to Reduce Medical Errors, Enhance Quality of Care

Expert Panel Issues Call-to-Action with New National Standards and Training Recommendations

WASHINGTON—January 26, 2005—According to findings from a study released today in a national briefing of healthcare stakeholders, the prevalent culture of poor communication and collaboration among health professionals relates significantly to continued medical errors and staff turnover. Additionally, a lack of adequate support systems, skills and personal accountability results in communication gaps that can cause harm to patients.

A national study of more than 1,700 nurses, physicians, clinical-care staff and administrators found that fewer than 10 percent address behavior by colleagues that routinely includes trouble following directions, poor clinical judgment or taking dangerous shortcuts. In all, the study pinpoints seven categories of problems that are frequently encountered, yet rarely addressed. The study was co-sponsored by the American Association of Critical-Care Nurses (AACN) and VitalSmarts, a company specializing in leadership training and organizational performance.

"This research validates what our 100,000 constituents have communicated to us as the number one barrier hindering optimal care for patients," said

Kathy McCauley, RN, PhD, BC, FAAN, FAHA, president, AACN. "Too often, improving workplace communication is seen as a 'soft' issue—the truth is we must build environments that support and demand greater candor among staff if we are to make a demonstrable impact on patient safety."

To drive the cultural transformation needed to improve communication in hospitals, AACN unveiled today a set of national standards to promote skilled communication and collaboration among nurses and other caregivers. The AACN standards and VitalSmarts recommendations emphasize the urgent need for hospitals to implement initiatives, especially communication training and education, to ensure that healthcare professionals deliver safe, high quality care to their patients.

AACN and VitalSmarts combined their resources to better understand communication problems in hospitals through the survey *Silence Kills: The Seven Crucial Conversations for Healthcare.* Among the study's key findings:

- 84 percent of physicians and 62 percent of nurses and other clinical-care providers have seen coworkers taking shortcuts that could be dangerous to patients.
- 88 percent of physicians and 48 percent of nurses and other providers work with people who show poor clinical judgment.
- Fewer than 10 percent of physicians, nurses and other clinical staff directly confront their colleagues about their concerns, and one in five physicians said they have seen harm come to patients as a result.

- The 10 percent of healthcare workers who raise these crucial concerns observe better patient outcomes, work harder, are more satisfied and are more committed to staying in their jobs.

"People frequently see these problems, but too often they fail to talk about them," says Joseph Grenny, president of VitalSmarts and co-author of VitalSmarts' *New York Times* best-selling books *Crucial Conversations and Crucial Confrontations*. "Healthcare professionals who embrace the findings of this study and start talking candidly and safely about these seven problems will find that outcomes can improve dramatically."

According to panelist Dennis S. O'Leary, MD, president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), communication is a top contributor to medical errors in healthcare facilities. "The standards and recommendations put forth today make an important contribution to beginning to solve the identified communication problems," said Dr. O'Leary.

Panelist Karlene Kerfoot, RN, PhD, CNAA, FAAN, senior vice president for patient care services and chief nurse executive at Clarian Health Partners in Indianapolis, explained that by focusing on workplace communication improvements, Clarian has experienced greater recruitment and retention success and improved safety overall.

"Nurses must be as proficient at handling personal communication as they are in clinical skills," said Connie Barden, RN, MSN, CCNS, CCRN, executive editor of *AACN's Standards for Establishing and Sustaining Healthy Work Environments: A Journey* to

Excellence. "According to the Standards, a culture of safety and excellence requires that individual nurses and healthcare organizations make it a priority to develop communication skills that are on par with expert clinical skills."

# # #

For copies of the Silence Kills study report and the *AACN Standards for Establishing and Sustaining Healthy Work Environments*, visit http://www.rxforbettercare.org.

With 100,000 members and constituents, the American Association of Critical-Care Nurses is the largest specialty nursing organization in the world. Its headquarters are located in Aliso Viejo, Calif. Founded in 1969, the association has more than 240 chapters in the U.S. and abroad and is working toward a healthcare system driven by the needs of patients and their families, where critical care nurses make their optimal contribution. Complete information about AACN is available at http://www.aacn.org.

A world leader in leadership training and organizational performance, VitalSmarts. (http://www.vitalsmarts.com) *provides products and services to hundreds of companies, including over 300 of the Fortune 500. For over twenty-five years, and with over 20,000 participants, the company principals have researched methods for bringing about systematic and lasting change.*

APPENDIX C

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DEATH RATE 70% LOWER AT NATION'S TOP-RATED HOSPITALS: HEALTHGRADES 11th ANNUAL HOSPITAL QUALITY STUDY

—The Most Comprehensive Annual Study of Hospital Quality in America Examines 41 Million Patient Records at 5, 000 Hospitals Over Three Years; Mortality Rates Improve Nationally—

—City and State-Level Hospital Death Rates Released—

—Hospital Quality Ratings Available Free to Consumers at HealthGrades.com—

GOLDEN, Colo. (October 14, 2008)—Patients have on average a 70 percent lower chance of dying at the nation's top-rated hospitals compared with the lowest-rated hospitals across 17 procedures and conditions analyzed in the eleventh annual *Health Grades Hospital Quality in America Study*, issued today by HealthGrades, the leading independent healthcare ratings organization.

While overall death rates declined from 2005 to 2007, the nation's best-performing hospitals were able to reduce their death rates at a much faster rate than poorly performing hospitals, resulting in large state, regional and hospital-to-hospital variations in the quality of patient care, the study found.

HealthGrades Hospital Quality in America Study, also found that if all hospitals performed at the level of five-star rated hospitals, 237,420 Medicare dealths could potentially have been prevented over the three years studied. More than half of those deaths were associated with four conditions: sepsis (a life-threatening illness caused by systemic response to infection), pneumonia, heart failure and respiratory failure.

The HealthGrades study of patient outcomes at the nation's approximately 5,000 hospitals is the most comprehensive annual study of its kind, analyzing more than 41 million Medicare hospitalization records from 2005 to 2007. The study examines procedures and conditions ranging from heart valve-replacement surgery to heart attack to pneumonia.

Based on the study, HealthGrades today made available its 2009 quality ratings for all nonfederal hospitals in the country at www.healthgrades.com, a Web site designed to help individuals research and compare local healthcare providers.

Full reports on death rate trends in each of the 50 states and the District of Columbia are available in the study. And, for the first time, HealthGrades has released hospital death rates for the nation's 15 largest metropolitan statistical areas: New York, Los Angeles, Chicago, Dallas, Philadelphia, Houston, Miami, Washington D.C., Atlanta, Boston, Detroit, San Francisco, Phoenix, Riverside-Inland Empire (CA) and Seattle. Large variation exists between major metropolitan areas.

"Geography should not be a major factor in patients' outcomes. If our nation's hospitals are to close the quality gap and guarantee an equally high level of

medical care for every patient, no matter where he or she lives, it will require a commitment by our nation and its communities to demand more from quality improvement," said Samantha Collier, MD, HealthGrades' chief medical officer and a study author. "Until then, it is imperative that anyone seeking medical care at a hospital do their homework and know the hospital's quality ratings before they check in."

The study's major findings are:

- The nation's inhospital risk-adjusted mortality rate improved, on average, 14.17 percent from 2005 to 2007, but the degree of improvement varied widely by procedure and diagnosis studied (range: 6.30% to 20.94%). Five star-rated hospitals' mortality rates continue to improve at a faster rate (13.18%) than 1- or 3-star hospitals (12.30% and 13.14%, respectively).
- Large gaps persist between the "best" and the "worst" hospitals across all procedures and diagnoses studied. Five star-rated hospitals had significantly lower risk-adjusted mortality across all three years studied. Across all procedures and diagnoses studied, there was an approximate 70 percent lower chance of dying in a 5-star rated hospital compared to a 1-star rated hospital. Across all procedures and diagnoses studied, there was an approximate 50 percent lower chance of dying in a 5-star rated hospital compared to the U.S. hospital average.
- If all hospitals performed at the level of a 5-star rated hospital across the 17 procedures and diagnoses studied, 237,420 Medicare lives

could have potentially been saved from 2005 to 2007.

- Fifty-four percent (128,749) of the potentially preventable deaths were associated with just four diagnoses: Sepsis, heart failure, pneumonia and respiratory failure.
- Variation in risk-adjusted mortality exists not only at the national level but also at the state and regional levels. The greatest quality differences between states occurred in hospital death rates for heart failure, pulmonary, stroke and cardiac surgery.
- The region with the lowest overall risk-adjusted mortality rates was the East North Central region (IL, IN, MI, OH, and WI), while the East South Central region (AL, KY, MS, and TN) had the highest mortality rates.
- The East North Central region (IL, IN, MI, OH, and WI), had the highest percentage of best-performing hospitals at 26 percent. Less than seven percent of hospitals within the New England region (CT, MA, ME, NH, RI, and VT) were top-performing hospitals.

In the study's analysis of hospital death rates, the following 17 procedures and conditions were analyzed: bowel obstruction, chronic obstructive pulmonary disease, coronary bypass surgery, coronary interventional procedures (angioplasty/stent), diabetic acidosis and coma, gastrointestinal bleed, gastrointestinal surgeries and procedures, heart attack, heart failure, pancreatitis, pneumonia, pulmonary embolism, resection/replacement of the abdominal aorta, respiratory failure, sepsis, stroke, and valve replacement surgery. The full study, along with its

methodology and state-by-state hospital-quality statistics, can be found at www.healthgrades.com.

HealthGrades' Star Ratings of Hospitals

On its Web site, HealthGrades offers, free to consumers, quality ratings of 27 procedures and treatments for every nonfederal hospital in the country. The Web site is designed so that consumers can easily compare patient outcomes at their local hospitals for procedures ranging from aortic aneurysm repair to bypass surgery. Each hospital receives a star rating based on its patient outcomes in terms of mortality or complication rates for each procedure or treatment. Hospitals with outcomes that are above average to a statistically significant degree receive a five-star rating. Hospitals with average outcomes receive a three-star rating, and hospitals with outcomes that are below average receive a one-star rating. Because no two hospitals or their patients' risk profiles are alike, HealthGrades employs extensive risk-adjustment algorithms to ensure that it is making fair *comparisons.*

About Health Grades

Health Grades, Inc. (Nasdaq: HGRD) is the leading healthcare ratings organization, providing ratings and profiles of hospitals, nursing homes and physicians. Millions of consumers and many of the nation's largest employers, health plans and hospitals rely on HealthGrades' independent ratings, advisory services and decision-support resources to make healthcare decisions based on the quality and cost of care. More information on the company can be found at www.healthgrades.com.

APPENDIX D

In the Literature

FIVE YEARS AFTER TO *ERR IS HUMAN*: WHAT HAVE WE LEARNED?

Five years ago, the Institute of Medicine (IOM) issued its landmark report on medical errors, *To Err Is Human: Building a Safer Health System*. The report's finding that as many as 98,000 people die each year due to medical errors ignited professional and public dialogue. Patient safety has since become a frequent topic for journalists, health care leaders, and consumers, but is health care any safer now? And if not, why not?

Two authors of the IOM report, Lucian Leape, M.D., of the Harvard School of Public Health, and Donald Berwick, M.D., of the Institute for Healthcare Improvement, endeavor to answer these questions in "Five Years After To Err Is Human: What Have We Learned?" (*Journal of the American Medical Association*, May 18, 2005). Despite finding small improvements at the margins—fewer patients dying from accidental injection of potassium chloride, reduced infections in hospitals due to tightened infection control procedures—it is harder to see the overall, national impact, Leape and Berwick say. "[T]he groundwork for improving safety has been laid in these past five years but progress is frustratingly slow," they write.

Accomplishments

While *To Err Is Human* has not yet succeeded in creating comprehensive, nationwide improvements, it has made a profound impact on attitudes and organizations. First, it has changed the way health care

professionals think and talk about medical errors and injury, with few left doubting that preventable medical injuries are a serious problem. "It truly changed the conversation," say Leape and Berwick. A central concept of the report—that bad systems and not bad people lead to most errors—has since become a mantra in health care.

The second major effect of the report was that it helped recruit a broad array of stakeholders to advance the cause of patient safety. In 2001, Congress responded to the IOM recommendations by allocating $50 million annually for patient safety research to the Agency for Healthcare Research and Quality (AHRQ), the lead federal agency for health care safety. Other important players that have emerged include the Veteran's Health Administration, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Centers for Medicare and Medicaid Services (CMS), as well as purchasers and payers. However, the most important stakeholders, say the authors, are the physicians, nurses, therapists, and pharmacists who have become much more alert to safety hazards and who are committed to making improvements on the front lines.

Clearly, the report has also produced real changes in the practice of health care. In 2003, JCAHO began requiring hospitals to implement 11 safety practices, including improving patient identification, communication, and "surgical site verification" (marking a body part to ensure surgery is performed on the correct part). More safe practices will be added in 2005. In addition, teaching hospitals initiated new residency training hour limitations in 2003, aimed at reducing errors due to fatigue.

Challenges

With all this growing awareness and activity, why is health care not measurably safer? The answers, the authors say, lie in the very culture of medicine. Creating a culture of safety requires changes that physicians may perceive as threats to their autonomy and authority. Fear of malpractice liability, moreover, may create an unwillingness to discuss or even admit to errors. Other issues include the complexity of the health care industry, with its vast array of specialties, subspecialties, and allied health professionals; a lack of leadership at the hospital and health plan level; and a scarcity of measures with which to gauge progress.

The current reimbursement system can also work against safety improvement and, in some cases, may actually reward less-safe care, the authors say. For instance, some insurance companies will not pay for new practices to reduce errors, while physicians and hospitals can bill for additional services that are needed when patients are injured by mistakes.

Next Steps

Despite formidable barriers, the authors expect to see dramatic advances in the next five years in the following areas: implementation of electronic health records, wide diffusion of proven and safe practices, spread of training on teamwork and safety, and full disclosure to patients following injury. However, while these advances will have an impact on reducing errors, they represent only a small fraction of the work that needs to be done. To create comprehensive, nationwide change, pressure must be applied to the health care industry. Public outrage, reformed reimbursement policies, and regulation can create some of

this needed pressure. In addition, the authors suggest payment incentives to accelerate widespread adoption. It may be equally important, they say, to create negative financial consequences for hospitals or organizations that continue to perform unsafe practices.

The single most important step, however, is to set and adhere to "strict, ambitious, quantitative, and well-tracked national goals," say Leape and Berwick. They urge AHRQ to bring together organizations, including JCAHO, CMS, and the American Medical Association, to agree to a set of patient safety goals to be reached by 2010. The most important lesson of the past five years, the authors argue, is that "we will not become safe until we choose to become safe."

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Clinical Effectiveness of Safe Practices

Intervention	Results
Physician computer order entry	81 % reduction of medication errors[a,b]
Pharmacist rounding with team	66% reduction of preventable adverse drug events[c]
	78% reduction of preventable adverse drug events[d]
Rapid response teams	Cardiac arrests decreased by 15%[e]
Team training in labor and delivery	50% reduction in adverse outcomes in preterm deliveries[f]
Reconciling medication practices upon hospital discharge	90% reduction in medication errors[g]

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[a] D. W. Bates, J. M. Teich, J. Lee et al., "The Impact of Computerized Physician Order Entry on Medication Error Prevention," Journal of the American Medical Informatics Association 6 (July/August 1999): 313-21.

[b] D. W. Bates and A. A. Gawande, "Improving Safety with Information Technology," New England Journal of Medicine 348 (June 19, 2003): 2526-34.

[c] L. L. Leape, D. J. Cullen, M. D. Clapp et al, "Pharmacist Participation on Physician Rounds and Adverse Drug Events in the Intensive Care Unit," Journal of the American Medical Association 282 (July 21, 1999): 267-70.

[d] S. N. Kucukarslan, M. Peters, M. Mlynarek, D. A. Nafziger, "Pharmacists on Rounding Teams Reduce Preventable Adverse Drug Events in Hospital General Medicine Units," Archives of Internal Medicine 163 (September 22, 2003): 2014-18.

[e] L. Landro, "The Informed Patient: Hospitals Form 'SWAT' Teams to Avert Deaths," Wall Street Journal, December 1, 2004.

[f] B. Sachs, Beth Israel Deaconess Medical Center, written communication, October 2004.

[g] J. D. Rozich and R. K. Resar, "Medication Safety: One Organization's Approach to the Challenge," Journal of Clinical Outcomes Management 8 (October 2001): 27-34.

22a

Ventilator bundle protocol	Ventilator-associated pneumonias decreased[h]

[h] J. Whittington, written communication, March 2005.

Source: L. L. Leape and D. M. Berwick, "Five Years After To Err Is Human: What Have We Learned?" Journal of the American Medical Association 293 (May 18, 2005): 2384-90.

APPENDIX E

Joint Commission Forms National Task Force To Review Relevance of Standards, Compliance Requirements

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(Oakbrook Terrace, Ill.—April 30, 2001) The Joint Commission on Accreditation of Healthcare Organizations today launched a sweeping review of its hospital standards and requirements for demonstrating compliance with standards.

An 18-member task force will pinpoint which accreditation standards are most relevant to the safety and quality of patient care, and target for elimination or modification those standards that do not contribute to good patient outcomes. In addition, the task force will identify redundant and overly burdensome documentation requirements for potential streamlining, and identify areas needing additional focus.

The project is part of a concerted effort by the Joint Commission to enhance the value and effectiveness of its accreditation process. The initiative will identify opportunities to streamline compliance activities for the nearly 5,000 accredited hospitals, allowing the organizations to pursue their efforts on improving patient care. The Joint Commission plans to conduct similar reviews for its seven other accreditation programs in the near future.

"Accreditation is about performance that directly impacts patient care and safety, not process and paperwork," says Charles A. Mowll, executive vice president, Joint Commission. "We want Joint Commission accreditation to continue to offer measurable benefits to hospitals and the patients they serve. A thorough, comprehensive assessment is crucial to ensure that Joint Commission standards accurately reflect the dynamic environment of health care today." Only a few recently established standards—such as groundbreaking requirements regarding pain management, patient safety and restraint and seclusion—are exempt from scrutiny. These standards have already been subject to the type of broad consensus-building efforts that the Joint Commission is now seeking for older requirements.

In addition, standards relating directly to Medicare Conditions of Participation (CoPs) for hospitals will receive special consideration. While the task force will identify potential additions, deletions or modifications to this subset of standards, the Joint Commission recognizes that these standards are the "law of the land" and are required for Medicare deeming. The task force's ideas, however, may potentially serve as the basis for Joint Commission discussions with the Health Care Financing Administration as changes are considered to CoPs.

Led by Ken Shull of the South Carolina Hospital Association, the task force will include quality directors, medical records directors, nurses, physicians, engineers, risk managers and other hospital leaders who have first-hand experience with Joint Commission accreditation standards and surveys. Furthermore, physician groups will be enlisted to specifically review medical staff standards.

"Many hospitals are faced with limited financial revenues, a national staffing crisis and an ever-increasing burden of compliance demands imposed by state and federal regulators, accreditors and managed care organizations," Shull says. "I welcome this invitation to work with my task force colleagues and the Joint Commission to offer constructive input on what most directly impacts patient care."

Specifically, the task force will consider the following criteria in reviewing standards:

- Continuing relevance in promoting patient safety or high quality care.
- Redundancy with other external quality requirements.
- Applicability of standards to hospital care.
- Likelihood that compliance will be consistently evaluated.
- Extent to which compliance can actually be measured.
- Linkage to patient outcomes.

The Joint Commission also will ask the task force to identify common misconceptions and misinformation regarding requirements for demonstrating standards compliance. These fallacies often result in unnecessary costs for hospitals in both staff time and resources.

In addition to the comprehensive standards review, the Joint Commission has in recent years made a number of significant changes intended to enhance the evaluation of critical patient safety and patient care functions and to achieve an accreditation process that remains consultative and centered on perform-

ance improvement. A redesigned on-site survey process now focuses more on individual-centered evaluations and allows more time for observation in patient care units. In addition, the Joint Commission is conducting pilot testing of a proposed model to assess staffing effectiveness and a more continuous survey process.

http://www.jcaho.org/news/nb324.html

APPENDIX F

The Joint Commission

Behaviors that Undermine a Culture of Safety

http://www.jointcommission.org/NewsRoom/PressKits/Behaviors+that+Undermine+a+Culture+of+Safety/app_stds.htm

Issue 40: July 9, 2008

Applicable Joint Commission Standards

Standard LD.03.01.01
Rationale for LD.03.01.01

Leaders create and maintain a culture of safety and quality throughout the [organization]. Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the [organization]. Leaders demonstrate their commitment to quality and set expectations for those who work in the [organization]. Leaders evaluate the culture on a regular basis. Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to [patient] care. Leaders must address disruptive behavior of individuals working at all levels of the [organization], including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Elements of Performance for LD.03.01.01

1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

2. Leaders prioritize and implement changes identified by the evaluation.
3. Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.
4. The hospital has a code of conduct that defines acceptable, disruptive, and inappropriate behaviors.
5. Leaders create and implement a process for managing disruptive and inappropriate behaviors.
6. Leaders provide education that focuses on safety and quality for all individuals. (See also LD.04.04.05, EP 6)
7. Leaders establish a team approach among all staff at all levels.
8. All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality.
9. Literature and advisories relevant to patient safety are available to all individuals who work in the hospital.
10. Leaders define how members of the population(s) served can help identify and manage issues of safety and quality within the hospital.

Medical Staff Standard
MS.4.00

Overview

Determining the competency of practitioners to provide high quality, safe patient care is one of the most

important and difficult decisions an organization must make. The development and maintenance of a credible process to determine competency requires not only diligent data collection and evaluation, but also the actions by both the governing body and organized medical staff.

The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant's licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.

Three new concepts are introduced in the revised credentialing and privileging standards. First, the revised credentialing and privileging standards have been informed throughout the six areas of "General competencies" developed by the accreditation council for graduate medical education Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. The areas of general competencies include the following:

- Patient Care
- Medical/Clinical Knowledge
- Practice-based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-based Practice.

Integrating these concepts into the standards allows the organized medical staff to expand to a more comprehensive evaluation of a practitioner's professional practice.

APPENDIX G

Swinging Pendulum of Peer Review Immunity

By Charles I. Artz, Esq.

Physician's News Digest—Published November 2001

http://www.physiciansnews.com/law/1101.html

Recent appellate court decisions in Pennsylvania and other jurisdictions raise the question whether the immunity afforded hospitals and reviewers under the federal Health Care Quality Improvement Act (HCQIA) have allowed the peer review system to be improperly utilized, or even abused in some cases.

HCQIA was enacted by Congress in 1986 to provide immunity against civil litigation damages for physicians and hospitals engaging in professional peer review, and to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of prior damaging or incompetent medical performance. Immunity under HCQIA can be established if the peer review process meets four general standards:

- It had an objective, reasonable belief that its action furthered quality health care.
- It made an objective, reasonable effort to obtain the facts.
- Under the *totality of the circumstances*, the physician being reviewed received adequate notice and hearing (i.e., due process) procedures.
- The organization had a reasonable belief that its actions were warranted.

Superficial review of this four-part test suggests physicians should receive due process throughout the

entire peer review, and serious quality of care issues must exist before a physician's privileges can be suspended, reduced or revoked. Case law and experience demonstrate the contrary.

Bias and Conflicts of Interest Immaterial

In *Manzetti v. Mercy Hospital of Pittsburgh*, the Pennsylvania Supreme Court held on July 18, 2001 that the hospital and reviewers were entitled to immunity under HCQIA. The Supreme Court disregarded all evidence relating to the reviewed physician's competitors' involvement in the case and attacks against him. The Court stated that any self-interest, bias or conflicts of interests by the reviewers were *immaterial*. According to the Court, the only time HCQIA precludes an economic competitor from involvement in the internal peer review process is at the hearing panel phase of the case; however, HCQIA does not preclude economic competitors from perpetrating due process violations and inculcating bias throughout the early phases of the review process. Under most hospital bylaws, by the time the physician gets to the fair hearing panel, the burden has shifted against the physician with the requirement that the physician prove by clear and convincing evidence that all prior decisions were arbitrary and capricious or factually baseless. Practical experience demonstrates this is a virtually impossible burden to sustain and standard to satisfy.

The Supreme Court also held that the "reasonable effort" prong of the four-part HCQIA immunity test is satisfied if the review activities are "sensible," but they do not have to be "flawless." Thus, the Supreme Court has countenanced due process violations and errors in the peer review process.

Sloppy, Negligent and Wrong Peer Review Warrants Immunity

In *Donnell v. HCA Health Services of Kansas, Inc.*, the Kansas Court of Appeals held on July 6, 2001 that physician peer reviewers are immune from liability under HCQIA even if their investigations are *sloppy, negligent, and wrong*. Physicians must prove bad faith and malice to have a peer review decision overturned.

This decision, like *Manzetti* above, allows a hospital to make serious mistakes about the quality of a physician's health care. It also permits termination of the physician's staff privileges, and the detrimental effect of a Data Bank entry, all with immunity from liability and practical impunity.

One Mistake and Done: Free Ride for Abuse

In Meyer v. Sunrise Hospital, the Nevada Supreme Court held on May 15, 2001 that a hospital's decision to terminate a physician based upon a single incident, regardless of the high quality of care the physician provided throughout the remainder of his career, was sufficient to protect the hospital under HCQIA's immunity provisions.

One Justice on the Supreme Court recognized the unfairness of the statute, but was compelled to uphold the decision. The Justice noted that HCQIA can sometimes be used, "not to improve the quality of medical care, but to leave a doctor who was unfairly treated without any viable remedy." That Justice also stated: "basically as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, whether legitimate or not, they are immune from liability, which leaves the

hospitals free to abuse the process for their own purposes."

No Constitutional Infractions

In *Freilich v. Board of Directors of Upper Chesapeake Health, Inc.*, a federal court in Maryland held on May 14, 2001 that the HCQIA immunity provisions do not violate due process or equal protection under the U.S. Constitution.

Review Must Be 100% Wrong?

In *Brader v. Allegheny General Hospital*, 167 F.3d 832 (3rd Cir. 1999), it was proven that the hospital's outside expert report had several incorrect conclusions. The Court of Appeals, however, ignored these mistakes because it found the report to be "otherwise thorough." The Court implied that the expert report must be entirely mistaken, and that the mistakes must be obvious. Because they were not, the hospital's decision was not unreasonable, and the first and fourth prongs of the HCQIA immunity test were satisfied.

Bias and Mistakes Early and Often Mean Nothing

In *Gordon v. Lewistown Hospital*, 714 A.2d 539 (Pa. Cmwlth. 1998), Commonwealth Court found that there is a presumption of validity of the hospital's disciplinary procedures. An outside consultant was retained. The Hearing Officer was an attorney, who was determined not to be in economic competition with the physician, but was a neutral party. Even though some of the physician's direct economic competitors were involved in the decision, and there was evidence of a history of hostility toward him, none of those individuals participated in drafting the outside report. The Court then looked to the *totality*

of the process leading to the professional review action. Under that broad test, even though some parts of the process were critically flawed and biased, the Court said, in totality, the physician got all the process he was due.

These cases are the latest in a series of decisions nationwide leaving physicians who are subjected to peer review without any legal remedies, and without any right to secure a fair hearing and a fair outcome.

The Dreaded Data Bank

An "adverse action" following peer review results in the hospital reporting (through the Medical Board) the physician to the National Practitioner Data Bank, commonly referred to as the "Data Bank." Many reports conclude physicians' care was "incompetent," "unprofessional" or other professionally disastrous terms. Economic experts have opined that such a negative statement in the Data Bank directly results in substantial economic loss to a physician. The Pennsylvania Supreme Court in *Hayes v. Mercy Health Corp.*, 559 Pa. 21, 739 A.2d 114 (1999) stated that a physician's Data Bank entry may, if left unchallenged, have a deleterious effect on the physician's medical career.

Money and Vengeance

The author has represented orthopedic surgeons, cardiologists, OB/GYNs, thoracic surgeons, anesthesiologists, ophthalmologists, family physicians, internists and other specialists in hospital peer review cases and medical staff privileges litigation. More often than not in the author's experience, peer review is initiated against a physician for one of three reasons: (1) by economic competitors for financial

reasons; (2) in retaliation against the physician for not "playing ball" in one manner or another (economic or otherwise); or (3) in retaliation for the physician raising concerns about other physicians' care and seeking to have those providers' outcomes reviewed. The state "whistleblower" law does not protect these physicians. The Pennsylvania Peer Review Protection Act, which allows physicians to litigate tort and contract breach claims in state court against hospitals whose peer review is effectuated by malice or bad faith, has been "trumped" (although not technically preempted) by the federal HCQIA immunity standards.

Shifting Sands

Hospital bylaws impose difficult legal standards and burdens on physicians. Typically, after a physician is the subject of an adverse recommendation or an adverse action by a medical executive committee, the physician is given a fair hearing. Traditional notions of fairness might lead one to believe that the hospital would have the burden of proof by at least a preponderance of the evidence to demonstrate the physician's quality of care was below some recognized and measurable standard warranting a quality of care concern. After all, hospitals have a legitimate concern about corporate liability and "negligent credentialing" following the Supreme Court's *Nason Hospital* decision in 1991.

Absolutely every set of hospital bylaws the author has reviewed do not contemplate a truly fair system for the physician being reviewed. Instead of the hospital accepting the burden of proof with a reasonable standard based upon measurable guidelines for quality infractions, the bylaws shift the burden of proof to the physician and create a nearly impossible

standard to overcome. The physician typically has the burden to prove that the hospital's decision was arbitrary and capricious. Some bylaws even state that the physician must prove that there was no material basis for the action or there was a complete absence of facts in the record to support the action. An utterly biased, sloppy, negligent and mistake-riddled report by an outside reviewer still cannot be overcome by this enormous burden if there is just a shred of truth in the report.

Practical Effect

As the case law outlined above illustrates, the physician's economic competitors and antagonists can initiate the peer review process, retain outside consultants and virtually direct the outcome of the report that will form the basis of the hospital's adverse action. After the antagonist's bias, conflict of interest, self-interest, direct economic competition and retaliation motives are all effectuated, they are immaterial and not reviewable by the courts, since all of those problems purportedly can be remedied by retaining a three-member independent panel to conduct the hearing.

Most fair hearing panels are truly independent. But, even if the panel calls "balls and strikes" fairly, the burden of proof and standard of review are so high it cannot be overcome practically. There is no legal remedy or recourse to the physician under the "totality of the circumstances" test. Hospitals have figured out that all they need to do is establish an independent fair hearing panel, give minimal due process at that final phase of the case, and their immunity will be intact.

JCAHO Doesn't Care

The JCAHO accreditation manual for hospitals contains medical staff standards. One standard requires "mechanisms, including a fair hearing and appeal process, for addressing adverse decisions for existing medical staff members and other individuals holding clinical privileges for renewal, revocation, or revision of clinical privileges." When discussing the broad HCQIA immunity and typical hospital bylaws burden shifting and standard setting procedures that are anything but fair and balanced, JCAHO staff take the position that they "don't care about detail" even if, as applied, the physician has no chance to overcome the standards.

Courts Don't Care

Although courts have no hesitancy involving themselves in the intricacies of physician practice in the context of medical malpractice liability, courts take a contrary view when physicians seek redress as a result of faulty peer review and retaliation. In *Lyons v. St. Vincent Health Center*, Commonwealth Court stated: "It is not up to the courts to second-guess hospitals in their decisions as to the best way to deliver services; it is up to the institution itself."

Early Intervention Strategy

A physician subjected to peer review may have little chance of surviving unless early and aggressive measures are taken. Understanding the case law and limitation on judicial remedies, it is prudent for the physician and counsel to quickly retain the best conceivable expert in the subject area to address the outside reviewer report. In many cases, it becomes very clear that the outside reviewer's report sig-

nificantly overstates quality of care infractions, is based on no published peer reviewed medical journal articles or positions, and is academically pedantic without taking into consideration reasonable and acceptable standards of care.

Successful resolution using this strategy can be achieved with minimal disruption to the physician, including perhaps CME and monitoring, without causing a damaging Data Bank entry.

Statewide Independent Peer Review

The process described in this article has led many physicians, and some organizations, to propose a statewide peer review requirement that would utilize independent, non-biased peer review organizations that make judgments based upon clearly acceptable standards, taking into consideration reasonable differences of opinion. Like a physician being judged for a licensure infraction, the burden of proof would remain on the entity seeking to impose discipline (the hospital) with at least a preponderance of the evidence standard, if not a clear and convincing standard. Only this level of independence would balance the playing field and return quality of care to the forefront of peer review.

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APPENDIX H

OVERTREATED

Why Too Much Medicine Is Making Us Sicker and Poorer

Shannon Brownlee

BLOOM SBURY

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botched several sex-change operations and cut off the wrong leg of a man who subsequently developed gangrene and died. An orthopedic surgeon became fixated on doing more surgeries than any other physician in his group, sometimes working eighty hours a week to keep up his productivity. The more surgeries he did, the sloppier he got, until he was routinely committing errors and getting sued for malpractice. In one case, he put in the wrong size screw to repair a patient's bone and refused to correct it when the head of the screw poked through the patient's skin. It's tempting to lay all medical error at the feet of bad doctors, but that can't be the whole story, as Harvard surgeon Atul Gawande points out, for the simple reason that good doctors make mistakes too. Studies of specific types of medical error suggest that it is not just a small subset of doctors who commit them, a rotten few who are responsible for all the problems. Rather, every physician is destined to make at least one horrible mistake in the course of a career—and most will carry the memory and shame of it for the rest of their lives. It isn't just doctors who err. Virtually every person who has direct responsibility for the care of sick people falls down on the job sometimes, and the more people involved in an individual patient's care—and the more procedures the patient undergoes—the more likely it is that somebody in the medical supply chain is going to blow it. Just think for a moment about the sheer number of people who have a hand in whether a patient lives or dies. There are the orderlies who must deliver blood samples to the lab on time and the pathologists who must correctly identify infectious agents so doctors can prescribe the right antibiotic. Pharmacists have to provide the right drug at the

right dose to the right patient. Somebody has to scrub down every bacteria-harboring nook of an operating room, thoroughly sterilize equipment and linens, stock supply closets, fill soap dispensers, and maintain heart monitors and ventilators. Every single person must do his or her job right every single time or risk the well-being of patients. When you think about how many people touch a patient, either directly or indirectly, and how many tasks they must perform with precision in order to keep patients safe, it' s hard not to wonder how patients ever leave at all.

THREE Your Local Hospital 72

To REACH SHASTA Regional Medical Center, just drive north from San Francisco on Interstate 5 for four hours, until you see Mount Shasta, floating over Siskiyou County in its permanent cloak of snow. The hospital sits in the middle of downtown Redding, near a bend in the winding Sacramento River. Known as Poverty Flats in the early nineteenth century, Redding was first settled by miners and loggers, who stayed until the mines were tapped out and the redwoods and pines were all cut down. The town revived in the mid-twentieth century. When it became a mecca for fishermen, hikers, and skiers headed for nearby Shasta and Trinity lakes, Lassen Volcanic National Park, and snowcapped Mount Shasta. Tourism is now one of two main businesses in this town of ninety thousand residents. Between them, Shasta Regional Medical Center and Mercy Medical Center employ more than two thousand people, and generate nearly one hundred million dollars a year in revenue. Dr. Patrick Campbell arrived in Redding with his wife and two children in 1993 less than two years out from his internship and residency at the University of California, Davis.

Campbell had been working in an urgent care facility in Sacramento when he was recruited by Redding Medical Center (which would be renamed Shasta Regional Medical Center in 2003). Redding offered a two-year salary guarantee, which would give Campbell time to build a practice and payoff medical school debts. From the hospital's perspective, good relations hips with primary care physicians like

Campbell were a matter of branding, well worth the recruitment costs: primary care doctors who were loyal to Redding Medical would admit patients to the hospital and refer them to the hospital's specialists, especially those in its busy cardiac program. To Campbell, Redding seemed to offer a good life. The crime rate was low, the schools were good and the area was beautiful. He could have a small-town practice that would let him get to know his patients over the years, while still having access to a modem, high-tech hospital. Campbell's high hopes and idealism at the outset of his career made the events that would unfold in Redding over the next decades—the lawsuit he would file in 2002, the evidence of malpractice and fraud committed by several heart specialists at Redding Medical that he would uncover, and the town's anger at him for exposing two of its most prominent physicians seem all the more surreal. After blowing the whistle on the hospital and its specialists, he would lose practically everything he valued, his medical practice, his family, and his home. The tale of Campbell and Redding Medical Center tells a larger story about the forces that drive all hospitals to deliver unnecessary care—and how difficult it is to rein them in. Campbell grew up in Portland, Oregon, the son of a secretary and a customs inspector, the

first person in his family to go to college. An accomplished violist in high school, he entered Lewis and Clark College with a full music performance scholarship. But after two years of college and a move to California, the early dream of an orchestral music career faded. He enrolled at the University of California, Santa Cruz, and switched to natural sciences. After an undergraduate degree in chemistry and three years as a graduate student, he finally settled on medicine, enrolling in medical school at the University of California, Irvine, where he met his wife. Both Campbell and his wife went into primary care. an idealistic decision at a time when more and more of their classmates were choosing to enter specialties where the money was much better. One of the first doctors Campbell met in Redding was a cardiologist, Chae Hyun Moon. The son of a Korean physician, Moon was a more ambitious breed of doctor. According to the New York Times, he graduated in 1972 from the College of Medicine at Yonsei University in Seoul and completed an internship and residency at Metropolitan Hospital Center in New York.

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His forceful personality and constant availability allowed him to quickly build a thriving practice in Redding. When Moon arrived in northern California in the early 1980's, all invasive cardiac services-cardiac catheterization, angioplasty. and open-heart surgery—were being done in bigger cities like Sacramento, two hundred miles away. Moon pushed for a cardiac catheterization laboratory—a special room containing the equipment needed to perform such procedures as balloon angioplasty—and open-heart-surgery capability in Redding. First Mercy Medical

Center and then Redding Medical opened labs, followed by an open-heart-surgery program, in 1987. Five years later, Moon and Fidel Realyvasquez, Jr., a Stanford-trained cardiothoracic surgeon were the dominant figures in their respective specialties. Together, the men built the California Heart Institute within the once-sleepy Redding Medical Center. Primary care physicians sent their patients from all over northern California, from tiny towns like Weed and Paradise, and from as far away as southern Oregon. Moon was always willing to accommodate another patient. As he would later tell the Sacramento Bee. "When these guys call me up day or night or holidays, it doesn't matter. I am in a health profession to save lives." Both heart specialists were workhorses, but Moon especially so. He focused his practice on catheterization, an invasive procedure that involves snaking a thin catheter, or tube, up through a major blood vessel in the groin into the coronary arteries, the blood vessels that supply the heart muscle with oxygen. Moon also performed balloon angioplasties, threading a tiny balloon up a wire inside the catheter. When the balloon was inflated, it could smash a clot against the arterial wall, allowing blood to flow freely once again. By the 1990s, cardiologists were also employing stents, tiny mesh tubes that could prop open a blockage inside a coronary artery. Moon sometimes performed as many as a dozen cardiac catheterizations in a single day-four to five times the number his peers in northern California were performing. In one year, he performed more than eight hundred invasive cardiac procedures. Between June 2001 and 2002, he billed Medicare for four million dollars. At its peak, Redding Medical Center was performing nearly eight

hundred open-heart surgeries per year—many of them done by Realyvasquez.

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With the enormous volume of procedures came high incomes and lavish lifestyles. Moon owned a rambling hilltop estate on the west side of Redding, with a view of Mount Shasta and No Trespassing signs posted at the bottom of the driveway. Realyvasquez lived on the east side, at the end of a tree-lined street behind an electronic gate. The doctors were popular figures in town. Realyvasquez donated his collection of fifty original Ansel Adams prints to a local museum. For eight years, Moon donated five thousand dollars annually to a scholarship for Shasta High School graduates interested in science or medicine. In a letter to the editor of the Redding Record Searchlight, the local paper, a resident wrote, "How lucky we have been that Dr. Moon chose this country to practice in." In the summer of 1993, a new patient, Mary Rosburg, came to Patrick Campbell with a multitude of physical complaints, including mild chest pains and shortness of breath. Rosburg and her husband spent summers living in their trailer in Trinidad, a small resort town on the California coast, just north of Eureka. Because she was having chest pains, Campbell gave Rosburg, who was in her sixties, a stress test, which involved asking her to walk on a treadmill while hooked up to a cardiac monitor. The test was inconclusive, but out of an abundance of caution, he referred his patient to Moon. Campbell assumed that the specialist would "work up" Rosberg that is, give her a series of mildly invasive tests, including another kind of treadmill test, that would help determine whether her complaints indicated heart disease. Instead, Moon went straight to a coro-

nary artery catheterization and promptly declared that she needed immediate bypass surgery and a heart valve replaced. Campbell was surprised both by the speed with which Moon used catheterization and by the diagnosis, but he assumed the cardiologist knew best. Later that same day, however, Campbell got another call, from a young cardiovascular surgeon who was a newly arrived partner of Realyvasquez's. In that doctor's opinion, Rosburg did not need surgery. Campbell was startled, but as a primary care physician just starting out in the community, he didn't feel he was in any position to question Moon's judgment. He suggested the surgeon talk to Moon directly. The next morning, Campbell's patient under-went the operation. Her recovery was

uneventful, hut several weeks later, while in Trinidad with her husband, Rosburg abruptly developed severe chest pain and shortness of breath. Flown back by helicopter to Redding, she was found to have a large blood clot on her new heart valve and underwent emergency surgery that night to replace it. Rosburg went into acute kidney failure and died within a week. Shaken by the death of a patient who had been essentially healthy just three months earlier, Campbell wondered if perhaps the surgeon who had called him had been right-that Moon's diagnosis had been incorrect. He concluded that he was in no position to review the records independently, and the surgeon in question left the area after one year. But after witnessing further examples of Moon's quickness to send patients to the cath lab and recommend open-heart surgery. Campbell began to worry in earnest that Moon and his group were being far too aggressive in their management of cardiac patients. Two years

later, Campbell would have hard evidence that patients were being given unnecessary care by the cardiologists in Moon's practice. During a routine office visit, Emma Jean Montgomery complained to Campbell about chest pain. Campbell reports that he sent her to one of Moon's partners. The cardiologist performed a stress test, then catheterization, and told Campbell by phone that the patient had severe, three-vessel coronary artery disease and needed immediate bypass surgery. The surgery was done the next day. When Campbell received the written report from her catheterization, two months after her surgery, he was shocked to see that the cardiologist had indicated that the patient had only mild to moderate coronary artery disease and that her chest pain was not caused by her heart. Not knowing which version to believe, Campbell obtained the images of her heart that were taken during her procedure and looked at them with Dr. Roy Ditchey, a local, board-certified cardiologist who had just relocated to Redding. Campbell says that Ditchey agreed: The woman's coronary arteries were not severely blocked, and she had not needed surgery More than once, Campbell and other physicians who were concerned about the hospital's cardiology program and its doctors would complain to Redding Medical Center administrators. At least once, a review was promised.

but over the years, as far as Campbell could tell, one was never actually undertaken. In the end, Redding Medical Center would be forced to shut down its cardiac program, after Campbell finally succeeded in alerting the Federal Bureau of Investigation and the Department of Justice. Medical records seized from the hospital were given to several outside heart

specialists, who found that in twenty-seven years at Redding, Moon had catheterized some 35,000 patients, a huge number for just one physician working in a lightly populated, largely rural area. In the opinion of the outside specialists, between one quarter and one half of the patients who underwent catheterization or surgery at Redding Medical Center had been operated on inappropriately. Justice Department documents stated that at least 167 patients had died during cardiac surgery, or shortly after, as a direct result of the Redding doctors' aggressive treatment. Either the patients had been too weak to withstand the surgery, or the doctors had been negligent, or they had committed errors, sometimes in haste to go from one patient to the next. In May 2006, the California State Medical Board moved to revoke Moon and Realyvasquez's licenses. By then Redding Medical's parent company, Tenet Healthcare Corporation, had agree to pay $59.5 million to the federal government to settle charges of Medicare fraud, at the time the largest settlement made by a health care company. A flurry of news reports appeared across the country, tracking the spectacular fall of Redding Medical Center. Most of the articles interpreted the events as an exceptional example of doctors run amok, or an isolated case of Medicare fraud, or an especially egregious episode in the ongoing saga of for-profit health care. But the story of a small hospital in northern California symbolizes a flaw in American medicine that goes far deeper—and is shared by nearly every single medical institution in the country.

No margin, no mission

The one concept that the media missed in covering the events at Redding Medical Center was that most

hospitals deliver unnecessary care. As patients, we want to believe that places like Redding and doctors like Moon

and Realyvasquez represent the rare case, and that a for-profit hospital so busy making money that its administrators did not want to acknowledge what was going on in their cardiac center is the exception, not the norm. Unfortunately, Redding Medical and its doctors were simply outliers at the far end of the spectrum of useless, unnecessary and potentially dangerous care that hospitals provide (even as they simultaneously fail to deliver other kinds of care that patients need). Unnecessary care, it turns out, is inevitable in a health care system like ours, partly because of the way hospitals are paid. All hospitals need to make money, and for the most part, as we've seen, hospitals and the physicians who work in them get reimbursed for how much care they deliver, rather than how well they care for patients—let alone how efficiently they deliver that care. When hospitals and doctors give patients medical procedures and tests they don't need, or when they fail to give patients care they do need, they are responding to the perverse incentives built into the byzantine and often—precarious reimbursement system that keeps them all afloat. In the days before health insurance and Medicare, most hospitals were run by religious charities, which operated under the motto "No margin, no mission." Their mission, of course, was tending to the sick, regardless of the patient's ability to pay; they tried to earn a small margin on the patients who could pay in order to cover the cost of their mission. Today, hospitals still need to run a profit to stay open, even nonprofits, which make up more than

three quarters of the more than five thousand hospitals in the United States—and most still turn to paying (or insured) patients in order to do so. From the humblest rural clinic to the most prestigious academic center, nonprofit hospitals generally earn at most between 2 and 6 percent profit on annual revenues, in part because forty-seven million Americans under sixty-five, or about one in six of us, have no health insurance. At most nonprofits, about 3 to 5 percent of patients are uninsured; at public teaching hospitals, it's a whopping 15 to 20 percent. In 2003, hospitals reported losing twenty-five billion dollars providing care for which they received no compensation. (Outside researchers suggest hospitals may be inflating their losses, which may be closer to sixteen billion dollars.)

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With its ideological preference for market-driven solutions. the Reagan administration was not about to approve price controls on hospital payments. Instead, the president signed a plan to impose the DRG system, an entirely new, draconian payment plan intended to create incentives for efficiency and reduce the number of details over which government and hospitals could quibble. The fee for each diagnosis group is set to reflect the average cost of treating that condition in an efficient hospital. If a patient is sicker than average and requires extra care, the hospital eats the difference. If the patient is healthier than average, or the hospital gets him back on his feet more quickly than average and he consequently costs less than average, the hospital gets to keep the change. The DRG system succeeded in providing a market incentive for efficient hospitals to make a small profit, while forcing inefficient hospitals to cut

expenses. Many hospitals responded by shutting down excess beds and slashing their lengths of stay, which had stretched out during the cushy cost-plus years. The system slowed the rate at which Medicare spending was rising to 8.6 percent between 1983 and 1984, the smallest annual increase since the program began. The following year the rate of increase dropped to 5.5 percent. (The rate of increase for hospital payments went to zero the year that Redding Medical Center's shenanigans came to light, with hospitals bending over backward to avoid over-charging Medicare.) But the DRG system also had an unexpected side effect, one that has helped drive the delivery of unneeded care in certain branches of medicine. Even though DRG fees are supposed to reflect actual costs. in reality they overpay for many procedures, especially many surgeries. At the same time, they underpay for other kinds of care. Take cardiac bypass, an exceptionally profitable surgery. in 2002, Medicare paid $24,000 per bypass surgery with cardiac catheterization while the average cost per case, according to a report put out by the Medicare Payment Advisory Commission (MedPAC), was $ 14,400, leaving $9,600 profit for every by-passed patient. Other cardiac procedures offer even higher margins: Replacing a heart valve, the surgery Patrick Campbell's patient Mary Rosburg underwent, can yield as much as 60 percent profit. The net profit hospitals make from these procedures drops when Medicare patients are sicker, of course, but even so, the

most common cardiac procedures typically performed on a heart attack patient earn about 6 to 16 percent over costs from Medicare reimbursement and more

than one hospital has made its entire margin on invasive cardiac procedures alone. Most private insurers don't use the DRG system, but rather a combination of negotiated payments and per diems that wind up being more generous in some markets than Medicare—and they too overpay on many procedures. From private payers, hospitals can reportedly make around $ 20,000 for an angioplasty procedure, about 40 percent of which is profit. On the flip side of the profit equation, the DRG payment for treating a heart attack patient with drugs alone and no surgical intervention—which for many patients is just as effective—produces about an 11 percent loss for the average hospital. What all this means is that any hospital administrator with an ounce of good business sense is going to want to maximize the number of patients in profitable service lines, which they have taken to calling "centers of excellence," whether or not they are, in fact, excellent. Even at academic medical centers, administrators exert subtle pressure on the physicians working in profitable departments to keep up their productivity by performing more-profitable procedures. In this sense, a hospital is no different from any other business. In recent years, IBM has shifted its focus from selling hardware to servicing large database systems where profits are higher. An even better analogy for the hospital industry is a low margin, high-volume business like personal computers. Dell earns only about 5 percent profit on each computer it sells, but it sells millions and millions of them. Similarly, hospitals want as many "bed turns:" or as much "throughput," as possible in their profitable departments. The best way to accomplish this is to expand the capacity of high-margin departments to increase volume. You can think of it as the Willie Sutton

strategy: Willie Sutton robbed banks because that's where the money is; hospitals invest in their money-making product lines because that's where the profit is. Yet, when hospitals focus not on profits but instead on providing care that helps patients, they often wind up being punished financially Several hospitals around the country have experimented with integrated, supportive

Investing in profit, not health. All of this goes a long ways in explaining why, in 1998, Redding Medical Center decided to expand its moneymaking product line—the cardiac procedures being performed by Realyvasquez and Moon. That year, the hospital earned $50 million in pretax profits, most of it from the California Heart Institute. "We were beyond full: one former administrator would later tell the New York Times." We were flying. The hospital constructed a five-story addition, known around town as "the Tower," much of which was devoted to expanded cardiac facilities. The Tower allowed Moon and Realyvasquez to recruit other cardiologists and surgeons to the area-and to bring in more patients. The cardiology specialists were not actually employed by the hospital; they had private practices and what's known as "admitting privileges," a relationship that is beneficial to both physician and hospital. Once known as the "doctor's workshop," a hospital is a little like a hotel filled with nursing staff, technology, and beds, where physicians are granted the privilege of admitting and treating patients. For hospitals, doctors are the medical equivalent of rainmakers in a law firm, the people who bring in the paying customers and most hospitals bend over backward to attract and keep physicians who can bring in patients

who are insured. "Hospitals need to understand who their customer is—the doctor who admits patients," as one neurosurgeon aptly puts it. With so much riding on the cardiac team, Redding administrators and the hospital's parent company, Tenet Healthcare, stroked and pampered Moon and Realyvasquez. The hospital appointed Realyvasquez chairman of cardiothoracic surgery and made Moon chairman of the cardiology department. Moon was also a member of the hospital board, and was eventually made head of the committee charged with overseeing the quality of cardiac care. The hospital sponsored golf tournaments to benefit the cardiac unit, sometimes offering Moon the use of its emergency helicopter to fly to the golf course. Moon's success and prestige gave him unusual clout for a physician; at one point, he was instrumental in persuading Tenet to dismiss a hospital executive. "No one would ever want to take [Moon] on," a former Redding administrator told the New York Times. "Moon was Redding Medical Center, and he knew it."

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By '999, Campbell had stopped sending patients to Moon if he could avoid it. He left his group practice and moved to another office, preferring to send his patients to Mercy Medical Center, the hospital across town. Still, he felt compelled to call attention to the situation at Redding. He strongly suspected that Moon, Realyvasquez, and their colleagues may have been charging Medicare and Medi-Cal, the state's Medicaid program for unnecessary procedures, not to mention putting patients at terrible risk. In March, he approached a local Redding attorney, asking his advice about how to get the government to investigate the hospital and its cardiac team. The attorney,

Jerrold Pickering, a longtime Redding resident who was a patient of Campbell's at the time, listened to the doctor's story for two hours before promising to look into the matter. Over the next two weeks, Pickering made several confidential inquiries to local Medicare officials, outside physicians, and the local district attorney's office. The lawyer then wrote Campbell a letter, telling him that the public authorities were not interested in pursuing the case. "The Medicare people shuffled around and around ... and were not really interested unless someone handed them a case fully worked up," he wrote. The district attorney was equally disinclined to pursue the issue, according to Pickering, even after he mentioned the death of one of Campbell's patients. Several of the people Pickering contacted knew about the problems at Redding Medical Center, wished any whistleblower well, but "would undoubtedly disappear when the first shot was fired." The conclusion is inescapable: Do not blow any whistle! Period. Rationale for this is: (1) you would be very alone, (2) there is too much money involved, (3) except for the victims and/or their families, no one cares, and (4) you would instantly find yourself with a bunch of new vigorous enemies." Several of those predictions would turn out to be painfully accurate for Campbell, who ignored the lawyer's advice and continued to search for a way to get Medicare to pay attention. Later that year, he came across an article in the magazine Medical Economics about a successful physician whistleblower and the federal False Claims Act, which is intended to encourage employees of companies that do business with the federal government to report fraud and abuse. Campbell called the physician, who referred him to

a New York law firm that specialized in whistleblower cases. The firm told Campbell he needed more cases to persuade the government that there was a serious problem worth investigating. But Campbell was unable to get other Redding physicians to produce any cases, even physicians who in private complained about Moon, Realyvasquez, and Redding Medical Center. By the summer of 2001, Campbell was deeply discouraged. He'd exhausted every option he could think of for alerting the authorities. His wife was fed up with his obsession, and he still had a busy primary care practice to tend to. A year later, Campbell got word that an FBI agent was nosing around town, asking questions after a few patients or their families had complained to the agency about the cardiac program. Throwing his lawyer's advice to the wind, Campbell called the agent. That was on a Thursday afternoon in August; the next morning he was sitting in the agent's office in Redding. Worried that the FBI agent would not believe him, Campbell arrived with over sixty pages of documents. After showing the agent his material, Campbell steered him to a nurse and two other physicians, who would eventually back up his claims that Redding's cardiac team was performing necessary cardiac procedures. On October 30, 2002, the FBI filed a sixty-seven-page search warrant affidavit with a judge, based largely on Campbell's information. That same day, more than forty agents from the FBI and the federal Department of Health and Human Services showed up without notice at Redding Medical Center and the doctors' offices and seized thousands of patient records and other evidence. Two weeks later, the stock price of Tenet Healthcare had tumbled from nearly fifty dollars a share to fifteen dollars. The

Justice Department's outside experts and a cardiologist hired by the state medical board would find a pattern of unnecessary and sometimes negligent care that represented "an extreme departure from standards of medicine," according to one physician who reviewed the records. In one case at Mercy Medical Center in 1996, Moon left a sixty-seven-year-old man who had suffered a massive stroke on the catheterization table, in the care of nurses without adequate instructions, and returned to his office. The man died soon thereafter. Moon would later defend his actions by saying he had done everything he could by picking up the phone and calling in a

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neurologist and a critical care specialist. When brought before peer review committees at Mercy to explain his actions, Moon fought back, ultimately filing lawsuits in state and federal courts against the hospital. The suits were eventually dismissed. Other patients of Moon and Realyvasquez survived but suffered long lasting, debilitating effects from their unnecessary surgeries. A local rancher named Stephen Hunt was only thirty-eight years old when he walked into the emergency room at Redding Medical Center just before Christmas in 2001, complaining of blurry vision in one eye. Hunt knew he had high blood pressure, but he was shocked when Moon told him he needed immediate bypass surgery—that he could suffer a heart attack and die on his way back to his car. Moon also told him there just happened to be an opening in the hospital's operating schedule on Christmas Eve. Hunt went ahead with the surgery. When the Justice Department gave Hunt's medical records to outside cardiologists, they found no evidence that the surgery had been needed. Hunt's

blurry vision cleared up once his blood pressure was successfully treated with drugs, but his life would never be the same after his surgery. He suffered a hernia at the incision site, which meant he could no longer do the physical labor of ranching: the fencing, bucking hay, and moving cattle. Five years later, he lost his ranch. On August 4, 2003, Tenet Healthcare Corporation agreed to pay $54 million to settle fraud charges brought by the federal government. In return, Redding Medical Center and Tenet were granted immunity from criminal prosecution. Ultimately, Tenet paid nearly $60 million to settle federal fraud allegations. and the Department of Health and Human Services permanently banned Redding Medical Center from receiving Medicare. Tricare (which insures members of the military), or Medi-Cal payments, effectively forcing Tenet to sell its former flagship hospital. The company eventually agreed to pay an additional $395 million in restitution to more than 769 patient s and their families who sued the company. In all, Tenet would pay the federal government more than $900 million to settle charges of unlawful billing practices at Redding and other hospitals. Shareholder lawsuits amounted to $ 2 15 million. In January 2003, Moon voluntarily suspended his practice. The California State Medical Board opened an investigation.

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Moon and Realyvasquee agreed to pay $ 1.4 million each in fines to the federal government, in lieu of criminal prosecution, while their Medicare billing privileges were revoked. There are many lessons to be drawn from the story of Redding Medical Center, beyond the obvious fact that physicians don't like to point fingers at colleagues, even when their reticence

allows patients to be harmed. But perhaps the most important lesson concerns the powerful effect that distortions in the reimbursement system can have on the decisions that hospital administrators make about how to invest capital resources. These distortions, coupled with policies dating back before the beginning of Medicare that built up the number of hospital beds until the early 1980s, have conspired to leave some cities, or parts of cities, with a surplus of certain kinds of beds and facilities—while simultaneously creating a shortage of others. In Los Angeles, for instance, there are two and a half times more intensive care unit beds per Medicare recipient than there are at the renowned Mayo Clinic, in Rochester, Minnesota, where nobody would argue that patients get substandard care. The result of this surplus of ICU beds in Los Angeles has meant that doctors are more likely to put patients in the ICU, whether or not they really need to be there. This kind of overinvesunent in profitable service lines can be seen in cities and towns across the country, in New York, Miami, and Los Angeles especially—precisely the cities where Jack Wennberg's group has found the highest rates of unnecessary care. We all wind up paying for it, as this overinvestment drives up costs for Medicare, state Medicaid programs, and private insurers. Meanwhile, more than a hundred emergency rooms around the country have closed in the past decade, victims in part of rising rates of uninsured patients appearing at their doors. At hospitals that have kept their emergency doors open, administrators have not been eager to add the additional ER beds that are often so desperately needed, because that would mean caring for more uninsured (and unprofitable) patients. Many cities now face a shortfall of emergency services, and hospitals rou-

tinely divert ambulances because their emergency departments are completely full. In Cincinnati, for example, diversions were so rare before 1998 that the city didn't even track them. By 2002, the total amount of time the city's hospitals were on divert

status had jumped to 1,970 hours annually, and the problem just keeps getting worse. In the month of December 2003 alone, emergency rooms were on divert status for 1.935 hours. That's the equivalent of nearly eighty-two days. I caught up with Patrick Campbell in June 2006, when he was living in Eugene, Oregon pulling twelve-hour shifts as a hospitalist overseeing the care of patients admitted to Sacred Heart Medical Center. When I spoke with Campbell over the phone, he recalled the events shortly after the FBI's 2002 raid in a tone of voice that veered between incredulity and resignation. "I remember a day after the raid, I had to go see a patient over at [Redding Medical Center], and people were looking at me with hatred," he said. "Within a week, everybody in Redding knew who had talked to the government, even though I was identified on the FBI affidavit only as 'D I.' "Stories appeared in the Redding Record Searchlight, reporting expressions of outrage among the local citizenry-not at Moon and Realyvasquez's alleged perfidy, but rather at their persecution by the federal government. The paper quoted Rhonda Arnold, a medical assistant in Moon's office, saying, "I've never met a man as honorable as Dr. Moon." Colleagues of the doctors said it was an injustice that patients would be "cardiac cripples" if not for Moon and Realyvasquez. On November 8, 2002, nine days after the raid, Campbell filed a qui tom (whistleblower) suit with the U.S. district court,

in Sacramento. A qui tam lawsuit is typically filed by a private party, alleging fraud against a federal agency. If the Justice Department investigates and the fraud is proved, it enables the government to recover up to triple damages and substantial penalties from the defendants—while the whistle-blower can potentially receive a portion of the government's recovery. By then, Campbell was pretty sure he was going to need the money to start over in another town. Patients had left his practice; colleagues avoided him. The town of Redding was angry with him. The state medical board would initiate, and ultimately drop, disciplinary proceedings against him, putting his medical license at risk, after a patient complained that Campbell had given the patient's confidential records to the FBI without consent. His popularity did not improve when the hospital began laying off employees. At one point, a group of nurses threatened to sue him for loss of employment. In June 2003, eight months after the raid, Campbell was stunned to learn that the Justice Department had moved to dismiss his whistle-blower suit in favor of another qui tam suit that had been filed just three days before his. The first-to-file whistle-blower was a Catholic priest named John Corapi, who had gone to Moon in June 2002 for what he thought was a routine cardiac checkup and had been told, like so many of Moon's patients, that he would die without immediate surgery. Unlike many patients, Corapi got a second opinion—in Las Vegas, where an old college buddy, Joseph Zerga, was an accountant. The doctors there told him that he had no significant coronary artery disease. When Corapi and Zerga complained to the Redding Medical Center CEO and got the brush-off they went to the FBI. The priest's legal standing as a whistle-blower was

questionable. The Justice Department was suing Tenet Healthcare and the doctors on behalf of Medicare; Corapi, who was in his fifties, wasn't old enough to be a Medicare recipient. The priest's contribution to the FBI's investigation consisted only of his own medical records; he had no personal knowledge of any other cases, and his case involved only an unnecessary cardiac catheterization and a recommendation for bypass surgery. The sixty-nine pages of documents that Campbell plunked down on the desk of the FBI agent, by contrast, contained case histories covering a ten-year period; a record of Redding Medical administrators' ignoring multiple efforts to bring Moon and Realyvasquez's actions to their attention; names of physicians and a nurse who could corroborate his story; and even a glossary of medical terms. Even so, the Justice Department took the position that Corapi and Zerga were the sole whistle-blowers, because they beat Campbell to the courthouse. In August, the court granted the Justice Department's motion to throw out Campbell's qui tam suit and subsequently enter into the $54 million settlement with Tenet Healthcare. Meanwhile, Corapi and Zerga stood to receive the entire 15 percent of the settlement owed to a whistle-blower, worth more than $8. 1million.

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It would take more than two years for Campbell and his lawyer to get the Justice Department's decision to remove him as a whistle-blower reversed. In the meantime, Campbell's practice In Redding dried up completely. His marriage foundered—"I wasn't the easiest person to live with," he said and in 2005, he left his wife and two children In Redding and moved to Eugene. When his lawyer filed an objection to the

Justice Department's decision, assistant U.S. attorney Michael Hirst, the prosecutor in the case, accused Campbell of being "driven more by greed than indignation." The prosecutor praised Corapi and Zerga, saying publicly, "Their willingness to blow the whistle on fraud resulted in our putting a stop to the surgeries and recovering $54 million." "That was a low point," Campbell told me. "It played out in the local paper as a battle between competing whistleblowers, a doctor and a priest, ducking it out in the courts." In November 2005, the court reinstated Campbell's qui tam suit and he agreed to settle for half of the whistleblower bounty, giving him nearly $4.5 million, before taxes and attorney's fees. Seven months later, in 2006, his wife and kids were driving up from Redding for a visit over the Fourth of July weekend. Campbell had not decided what he would do next. In the weeks leading up to the settlement, he had imagined that it would bring some sort of relief, a sense of closure, and maybe even a small measure of vindication. But when I spoke with him, Campbell sounded tired. Some days, he said, he thinks he will set up a new practice in Eugene or elsewhere; on other days, he wants to abandon medicine entirely and embark on a new career. Neither Moon nor Realyvasquez has ever admitted any wrongdoing. Shortly after the raid. Moon appeared genuinely devastated by the charges. Telling reporters his only goal had been to keep his patients safe from heart disease. He wept when a group of supporters strung up a banner that said, WE SUPPORT OUR DOCTORS! outside the courthouse. Maybe Moon and Realyvasquez and the hospital were deliberately bilking Medicare, as the Justice Department's charges against them indicate. Or maybe, as Moon

and Realyvasquez claim, they were making judgment calls within the wide latitude.

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permitted by the art of medicine, the uncertainty of cardiology. If that's the case, then the saga of Redding Medical Center points to the desperate need in medicine for clearer standards and better evidence for what works and what doesn't. The story of Redding also highlights the need for a new way to pay doctors and hospitals, a system that doesn't allow financial imperatives to propel clinical decisions.

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Too many patients. Give them the time to practice preventive medicine. (VHA primary care doctors are responsible for about fifteen hundred patients, at least five hundred fewer than the average internist or family physician.) Use information technology to improve coordination among doctors. Make hospitals and doctors accountable by measuring their performance and the outcomes of their patients. And finally, gather evidence for what works and what doesn't. We could call this strategy CARE, for coordination, accountability, electronic medical records, and evidence. While the tasks are clear, implementing CARE around the country won't be simple. In order to do it, we have to rethink the way we pay doctors and hospitals. The first step is for Medicare to address the way it overpays for certain procedures, like radiology and bypass surgery, and underpays for less-intensive care. The current system encourages hospitals to invest in expensive doctors and beds and technology that aren't necessarily what patients need. But there are other ways the payment system makes it hard for doctors to coordinate their care and

leads to unnecessary hospitalizations. Take the example of caring for diabetics. More than thirty million Americans have diabetes, the product of our ever-increasing girth and sedentary lifestyle. Over 60 percent of Medicare spending goes toward patients with chronic conditions like diabetes and heart disease, and the majority of the money is spent on hospitalizations for complications that could have been prevented with proper care. But keeping diabetics out of the hospital requires constant monitoring. Diabetics who fail to control their blood sugar are more likely to go blind, suffer heart attacks, or have a leg amputated because of a wound that won't heal. Preventing those complications isn't rocket science; it just takes constant work. Patients need to learn to eat better and exercise. They need to monitor their blood sugar and take their insulin or other drugs. They need to see an ophthalmologist regularly to check for damage to the retina and a podiatrist to ensure they are caring for their feet. And their doctors need to check their hemoglobin on a routine basis to make sure they are controlling their blood sugar at home. How often does all of this coordinated care actually happen? Outside of a few systems, like the VHA, Group Health, and Kaiser, rarely at best. Let's

look at just one piece of this puzzle, monitoring hemoglobin. If you have diabetes, your chances are about one in four that a doctor will actually perform that test, let alone teach you to check your own blood sugar level on a regular basis. According to a recent RAND Corporation study, failing to get their blood sugar checked leads an estimated twenty-six hundred diabetics to go blind every year and another twenty-

nine thousand to experience kidney failure. Doctors and hospitals don't neglect to treat diabetics properly because they are lazy or incompetent or don't care about their patients. They fail to do it in part because the payment system punishes them financially when they do. About seven years ago, a group of idealistic doctors in Bellingham, Washington, a bucolic coastal town about an hour north of Seattle, created Pursuing Perfection, a program to help participating medical practitioners prevent diabetes and chronic heart failure and to better care for patients who already have the conditions. The program centers on multidisciplinary teams employing the best practices for counseling patients, helping them to navigate the health care system and control their diseases. It also calls for preventive measures, providing access to nutritionists and nurses to help patients learn to eat better and exercise more in order to avoid getting the conditions in the first place. The doctors have implemented information technology to allow everyone involved in a patient's care to share medical records and support disease management. Pursuing Perfection has already improved the health of many patients. Rebecca Bryson suffers from both diabetes and congestive heart failure. Before enrolling in the program she was seeing fourteen different doctors and taking forty-two medications. When her lungs would fill with fluid from her congestive heart failure, she would call a doctor's office and tell the nurse what was happening. Sometimes she would get a call back in an hour, sometimes not for a day. She landed in the emergency room routinely. Under the new plan, she has access to a nurse, called a clinical specialist, who knows her case intimately, helps her adjust her medic actions, and gets her in to see the doctor when she needs it. Bryson also has access to

her own electronic medical record, where she can note reactions to a new medication. With the help of her clinical specialist, Bryson has learned how to avoid

going to the doctor by doing things like checking on the salt in her diet if her blood pressure goes up. These simple steps have had measurable results for patients across the board, reducing blood sugar levels in diabetics and preventing crises in heart failure patients. Pursuing Perfection has not only improved the lives of patients like Rebecca Bryson, it is saving both Medicare and private insurers thousands of dollars per patient and could cut deaths from diabetes by half. But Pursuing Perfection is killing the local hospital. Between 200 I and 2008, the initiative will have cost Peace Health's St. Joseph Hospital, in Bellingham, $7.7 million in lost revenue because patients aren't being admitted as often. The county's specialists stand to lose $ 1.6 million from lost procedures and office visits, and from having to spend time with patients without being compensated. Insurers won't (pay for a nutritionist to teach diabetics how to eat properly. They pay podiatrists well to perform procedures, but not to help a diabetic learn to inspect his own feet. One group of sixty doctors, at the Madrona Medical Group, who took part in planning the initiative, have withdrawn from the program because participating will cost them too much money. This is the sorry state of American health care. Doing what's best for patients is bad for business. The problem here is not that there's no money; it's that the money flows through the system in the wrong way. Hospitals are paid for each episode of care, each hospitalization, and doctors are paid for

each office visit, each procedure. They aren't paid to coordinate the care of diabetics or heart failure patients, to hire nurses to track a patient 's weight or make sure his lungs aren't filling up with fluid, or a nutritionist to help a diabetic understand what she can and cannot eat. In order for programs like Pursuing Perfection to succeed, hospitals must work with all local doctors, not just those who are willing to lose money in order to help their patients. The way to do that is to pay them as if they were a single, integrated group, hospitals and doctors working together. But that's not how we do it. Instead, our insurers pay the hospital one fee and the individual contractors who work in it—the doctors-another. Medicare officials are well aware that their own payment system is working against the health of patients, and they have proposed a solution to the

problem of poor quality called "pay for performance," or "P4P." In phase one, hospitals receive a small bonus for monitoring their own performance on seventeen measures of quality. Most hospitals are now checking such things as what percentage of diabetics receive an eye exam once a year and how often heart attack patients are given instructions to take aspirin or a prescription for beta-blockers. More performance measures will be added to the list as the plan progresses. In phase two, hospitals will be paid another small bonus for actually improving their scores on each measure. Hospitals that are below average will eventually be fined. Medicare is also test-driving a similar plan to measure the performance of individual physicians. Doctors fear that they will be measured on things they can't always control. Say a physician has a group of diabetics, for instance,

and she's taking great care of them, monitoring their blood sugar regularly and helping them stay out of the hospital. But one of her patients simply won't do what's necessary to keep himself healthy. He refuses to measure his blood sugar. He doesn't take his insulin. And he eats anything he wants, no matter how his doctor exhorts him to change his ways. When Medicare then measures that doctor's performance, she may look bad because of one recalcitrant patient. It's also difficult to measure an individual doctor's performance because patients move between doctors so often, and they see multiple specialists, making it difficult to assign responsibility for an individual patient to a single primary care physician. But the larger reason we shouldn't be measuring individual doctors is that it doesn't foster cooperation among them. Medicare'sP4P plan for hospitals won't either, because it focuses too narrowly on individual aspects of a web of events that must happen in order for a hospital to care properly for a patient. Focusing on a few discrete measures is like saying you are going to make a building earthquake-proof by bolting the furniture to the floor, or reform Social Security by switching to a cheaper brand of ink for writing the checks. The question is, how can we move the five thousand hospitals and eight hundred thousand physicians in this country to organize themselves into cooperative groups? One way to do it would be to allow the VHA to take over failing hospitals. My colleague Phillip Longman, in his book Best Care.